# STATE TITLE V BLOCK GRANT NARRATIVE
# STATE: NE
# APPLICATION YEAR: 2006

# I. GENERAL REQUIREMENTS

## A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

## B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

## C. ASSURANCES AND CERTIFICATIONS

Assurances and Certifications, signed by Director, Nebraska Health and Human Services, are maintained in the administrative files for Nebraska Title V/MCH Block Grant located in the Office of Family Health, MCH Planning & Support. The documents may be inspected by contacting the Title V/MCH Grant Administrator, (402) 471-0197 during regular business hours Monday-Friday, 8:00 a.m.-5:00 p.m. Central Standard Time, or sending a written request to Nebraska Health and Human Services, Office of Family Health, P.O. Box 95007, Lincoln, Nebraska 68509-5007.

## D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

## E. PUBLIC INPUT

A 50-member stakeholder group first organized in 2003 to bring a public perspective to the five-year needs assessment process. Representation was diverse and included consumers, state legislative from various settings including local health departments, community action agencies, hospital, and academia. Participants represented rural and urban, and included racial/ethnic minority populations of Native Americans, African Americans, and Hispanics. The group met during 2003 - March 2005 when the priorities were established. In 2005, five work groups reviewed data of subpopulations, each meeting three times to identify and present significant problem statements for the large group prioritization meeting in March. Group consensus was achieved. Data sheets are posted at http://www.hhs.state.ne.us/fah/RFP.htm.

The priorities established through this mechanism of public input were used to guide funding decisions for state- and community-level funding obligated in June and August 2005 for the fiscal beginning October 1. In addition, members of the stakeholder group will be invited to additional meetings planned by the Office of Family Health beginning in Fall 2005 to expand public input to include strategy development centered on the priorities.

## II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

## III. STATE OVERVIEW

## A. OVERVIEW

. Principal characteristics of Nebraska important to understanding the health needs of the entire state's population.

a. Large geographic area
Nebraska is located in the east-central area of the Great Plains midway between New York and San Francisco. Nebraska is generally rectangular in shape with a protruding area in the northwest corner called the Panhandle. The Missouri River bounds the eastern border between Nebraska and Iowa. Missouri, Kansas, Colorado, Wyoming and South Dakota surround Nebraska on the other borders. The State measures 387 miles across, including the western panhandle. The diagonal from northwest to southeast measures 459 miles, and the southwest-northeast diagonal is 285 miles. The state's area is 77,227 square miles, almost 20% larger than all of New England.

Nebraska's large land expanse creates unique health service delivery issues. In rural counties, about 18% of the population are 65 and over, and in 37 counties, the number of persons over age 65 exceeds 20%. This trend has important implications for the delivery of health and medical services because an older population needs more services

Nebraska's population centers are Omaha, Lincoln and several smaller cities scattered along the Platte River and Interstate 80 (which together bisect the state from east to west). Only Omaha and Lincoln (60 miles apart) represent Metropolitan Statistical Areas (MSAs) larger than 50,000 population.

b. Urban and rural
The total population of NE is projected to grow 11% by 2020. Although Nebraska's total population has grown considerably during the 1990s, many small rural counties that are not near a regional economic or health center continue to decrease in size. Most of the decrease in these counties resulted from out-migration of the younger population (18 to 45 years). Smaller population bases make it more difficult to recruit and retain physicians and other health care professionals. A small population base also makes it more difficult to operate institutional services, such as hospitals, and finance other types of services such as mental health, public health, emergency medical services, and long-term care services.

Nebraska's geography shows the state to be a primarily rural and sparsely populated state by national standards, with 32 out of 93 counties as frontier counties (6 or fewer persons per square mile). In contrast, approximately 50% of the state's citizens reside in the population centers of Lincoln and Omaha in the eastern part of the state. The urbanization of Douglas and Sarpy County (Omaha), and Lancaster County (Lincoln) is represented by an average population increase of over 10% between 1990 and 1998.

c. Increasing diversity
Another source of change is Nebraska's rapidly increasing diversity in a state previously regarded as homogeneous. Nebraska currently has its highest percentage of foreign-born residents since the 1870's. Minority populations are growing rapidly in both urban and rural parts of Nebraska. According to the US Census, the state's minority population grew by 23% between 1980 and 1990, and racial/ethnic minorities were found in every Nebraska County. From 1990 to 2000, the minority population rose by 83.5% (from 118,162 to 216,769) and now constitutes 12.7% of the total population while the white population increased by 2.2%. Most of this increase in minorities is Hispanic, whose numbers increased 255%, 40% of the state's overall population increase. However, they are not alone. Nebraska may have one of the largest Sudanese communities in the country. Numbers of Sudanese, Somalian, Bosnian and Vietnamese residents have jumped over the past decade.

In general, the minority population tends to be younger, have lower incomes, higher poverty, and less

insurance coverage. They are also more likely to be employed in high-risk occupations such as meat packing plants and farm labor. As a result, these population groups often experience difficulty gaining timely access to health and medical services. Even when services are available, language and cultural barriers prevent effective utilization of these services. There is a need to optimize these services for minority populations using culturally sensitive tools.

Nebraska's vision of healthy individuals, families and communities can only occur if racial and ethnic minority populations have equal opportunities for good health. To bridge the gap between the wide disparities in the health status of racial/ethnic minorities and the white population, it is essential to address the high risk factor prevalence, the major barriers that limit access to high quality health care services, and the need to develop effective local public health services across the state.

(1) Immigration
(a) Hispanic origin
The largest minority group in the state is the Hispanic American population which experienced the most dramatic increase by more than doubling from 37,200 in 1990 to 106,918 in 2003 (a 187% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 6.1% of the state's population. Douglas County, in 2000, had a Hispanic population of 30,928 people. Not surprisingly, these are the highest numbers in the state.

The Hispanic American population is expected to increase considerably by 2025. It is estimated that the number of Hispanic Americans in the state will reach 145,000 by 2025, an increase of 36% of the current population estimate. With the availability of employment, the Hispanic population in the central and western part of Nebraska has increased considerably. According to the U.S. Census, Dakota, Dawson, Colfax, Scotts Bluff, Hall, and Morrill counties have a Hispanic population greater than ten percent.

(b) Asian and Pacific Islander
Nebraska's Asian and Pacific Islander (API) grew from a population in 1990 of 12,629 to 29,058 in 2003, according to the U.S. Census Bureau estimates. The Asian/Pacific Islander population is expected to increase considerably by 2025. The Census Bureau estimates that this population will reach 40,000 people, an increase of 38%.

(2) Native American
The Native American population in Nebraska grew by 15.7%, from 12,874 in 1990 to 16,298 in 2003, according to the U.S. Census estimates. Native Americans currently comprise 0.9% of Nebraska's total population. Thurston County, home of the Omaha and Winnebago Tribes, ranks number 26 in the U.S. for percentage Native American. Almost half of the county's population is Native American (52%). Four federally recognized Native American tribes are headquartered in Nebraska, the Santee Sioux, Omaha, Winnebago, and Ponca. The Native American population is expected to increase considerably by 2025. Nebraska's Native American population will increase to 25,000 people, an increase of 53%.

Though many of Nebraska's Native Americans live on reservations, the majority does not. The urban areas of Omaha and Lincoln account for more than 33% of the state's Native American population, although they make up only a small proportion of these counties' total populations. A sizable group also exists in the northwestern part of NE adjoining the Pine Ridge Reservation in South Dakota. Among the state's reservations, the Winnebago and Omaha reservations in Thurston County account for 22% of Nebraska's Native American population. An additional 3% reside at the Santee Sioux Indian Reservation in Knox County. The Iowa and the Sac and Fox Indian Reservations on the Nebraska-Kansas border account for about 1% of Nebraska's Native American's total population.

(3) African American
African Americans make up 4.0% of the Nebraska population. This population grew from 58,047 in 1990 to 68,541 in 2000, an 18.1% increase. The African American population is expected to increase considerably by 2025, with growth projected at 63% (to 109,000 people). Almost 90% of Nebraska's

African American population are located in the most populous counties (Douglas, Sarpy and Lancaster). This growth is fueled by a large number of African immigrants, particularly from Sudan and Somalia; Nebraska may have one of largest Sudanese communities in the country.

(4) Minority Health Professionals
Cultural differences can and do present major barriers to effective health care intervention. This is especially true when health practitioners overlook, misinterpret, stereotype, or otherwise mishandle their encounters with those who might be viewed as different from them as they do their assessment, intervention, and evaluation. Health care professionals' lack of knowledge about health beliefs and practices of culturally diverse groups and problems in intercultural communication has led to significant challenges in the provision of health care services to multicultural population groups. The cultural diversity of the health care workforce itself can present problems that can disrupt the provision of services because of competing cultural values, beliefs, norms, and health practices in conflict with the traditional Western medical model.

While Nebraska has become an increasingly diverse state, its medical practitioners have not. In 2002, only about 1.2% of Nebraska physicians was African American, although this group makes up 4% of the state's population. This is less than the U.S. average; approximately 4% of all US physicians are African American. Only six Native American physicians practice in NE (0.2% of all physicians) yet this minority group makes up 0.9% of the population.

People of Hispanic origin comprise 6.1% of the state's population and are the fastest growing population group, but account for only 1.3% of Nebraska physicians. Asian Americans are well represented in the physician population. This group makes up only 1.7% of the population of the state, but accounts for 5.3% of physicians.

Additional barriers of receipt of health care were identified for racial and ethnic minority women in Nebraska. One-third of Asian American women (34%) and 12% of Hispanic women reported that language "always," "nearly always," or "sometimes" kept them from getting needed health care, according to a Nebraska Minority Behavioral Risk Factor Survey (NMBRFS).

Respondents to the NMBRFS were asked whether or not they felt racial or ethnic origin is a barrier to receiving health care services in their county. Nearly half of African American women (45%), 40% of Native American and 38% of Hispanic women "strongly agreed" or "agreed" that race or ethnic origin is a barrier. More than one-fourth (28%) of Asian American women expressed agreement with this statement.

(5) Racial and ethnic health disparities
As in other states, Nebraska's minority population has many health disparities. For example, according to an September 2003 report from the NHHSS Office of Minority Health, life expectancy for a Nebraska woman who is white is almost six years longer than for a Nebraska woman who is African American and more than ten years longer for a Nebraska woman who is Native American. African Americans have the highest rates of low-weight births and infant deaths in Nebraska. Native Americans in the state are five times more likely to die of diabetes-related causes than white persons. The CDC's "Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality" showed that Nebraska has one of the highest heart disease death rates in the country for African American and Native American women.

d. Aging population
Another significant trend is the aging of the state's population. In 2000, the percentage of the population aged 65 and older was 13.6%, compared to the national average of 12.4%. The total number of Nebraskans over age 65 increased by 4.1%, or by 9,127 individuals, from 1990 to 2000. Nebraska ranks 11th in the nation for percentage of population 65 years and over, however NE ranks only 44th in the nation for percentage change from 1990 to 2000. The population over 65 is projected to grow 48% by 2020. Nebraska ranks 6th in the nation for percentage of the population aged 85 years and over at 2.0%. This is a slight increase from 1990 (1.9%). The total number of people aged

85 and over increased by 4,751 individuals, or by 16.3%. NE ranks 50th in the nation for percentage change from 1990 to 2000.

In rural counties (those with populations of less than 20,000 people) about 18% of the population is 65 and over and in 37 counties the number of persons over age 65 exceeds 20%. Hooker County, Nebraska, ranks 2nd of all U.S. counties for percentage of population over 85 years of age at 6.3%. Nebraska has 17 counties (18%) of its counties in the top 100 of all U.S. counties for percentage of population over 85 years of age. The median age of Nebraskans increased from 33.0 in 1990 to 35.3 in 2000.

This trend has important implications for the delivery of health and medical services because an older population needs more services. However, a shrinking total population base reduces the number of people in the service area. The net result is that fewer health and medical services are available to meet the needs of the population. These inadequate services are further compounded by the lack of public transportation services in most rural areas of the state. As Nebraska struggles to maintain health care delivery in rural areas, services for older adults become increasingly fragmented and challenging.

e. Special populations
(1) Incarcerated
In Nebraska the average number of women incarcerated is 254. Using national estimates, 63% of incarcerated women have at least one minor child, and approximately 40% have more than one child under age 18. Nationally, 2.1% of the nation's children had a parent in State or Federal prison. African American children were nearly 9 times more likely to have a parent in prison than white children. Hispanic children were 3 times as likely as white children to have an inmate parent. The number of children with a mother in prison nearly doubled since 1991, while the number of children with a father in prison grew by 58% during this period.

(2) Homeless
The Nebraska Homeless Assistance Program (NHAP) makes funds available to nonprofit organizations through grant awards in order to serve the needs of people who are homeless and near homeless in the state. According to NHAP data, 20,307 people were homeless in Nebraska during the grant year July 2003 to June 2004 and 31,024 people were near homeless during this same time period. These figures include 12% homeless/8% near homeless unaccompanied women, 4% homeless/2% near homeless unaccompanied youth, and 39% homeless/54% near homeless single parent families. During the grant year, Hispanic or Latino persons represented 17 % of persons who were homeless and 11% of those who were near homeless. This year, during the first six months of the grant cycle (July 1, 2004-December 31, 2004), the same agencies and programs assisted 24,099 persons who were homeless and 34,826 who were at imminent risk of homelessness. Both figures exceed those assisted in each category during the prior grant cycle. It is important to note that the data is limited to numbers provided by monthly NHAP Reports received from NHAP programs statewide.

f. Rural poverty
Five of the nation's 12 poorest counties in 2002 were in Nebraska (US Dept. of Commerce). Loup County ranked as the nation's second poorest (per-capita income of $9,281 vs. national per-capita income of $30,906).

2. Agency's current priorities and initiatives with Title V programs' roles and responsibilities.

A description of the Agency's priorities and initiatives first requires an understanding of changing organizational structure. During FFY 2004, administrative changes at the Department head level have an impact on the Office of Family Health. In January 2004, the Governor appointed the Department's Director, Ron Ross, to be the State's new Treasurer, filling a vacancy created through a resignation. A new Department Director was chosen, Nancy Montanez. Ms. Montanez, assuming leadership in a time of major reforms chose to assign line authority for the Health Services branch of the Department

to the Chief Medical Officer, Dr. Richard Raymond. This assignment, executed through a Memorandum of Understanding, gave Dr. Raymond full authority and responsibility for programs and activities carried out in this branch, which includes the Office of Family Health and administration of the Title V/MCH Block Grant.

Early in FFY2005, further organizational changes occurred, with Dr. Raymond being named Director of the Department of Health and Human Services Regulation and Licensure. Being a physician, his role as Chief Medical Officer was subsumed into his new title and role. This change more closely aligned the Office of Family Health and Nebraska's Title V administrative activities with HHS Regulation and Licensure. At the same time, a Memorandum of Understanding placed the Office of Aging and Disability Services and Nebraska's Title V/CSHCN Program in the Department of Health and Human Services Finance and Support.

Finally, during the 2005 legislative session, LB 301 was passed and signed into law, making the organizational placement of Health Services, including the Office of Family Health, in HHS Regulation and Licensure a statutory placement, effective July 1, 2005.

So though Title V/MCH and Title V/CSHCN are still both within the Nebraska Health and Human Services System, they are now in different agencies, with different directors and differing agency priorities and initiatives.

In March 2005, HHS Regulation and Licensure identified its 2-year priorities to be: 1) make better use of technology (credentialing processes, health data storage/tracking, etc.); 2) marketing of public health; 3) sound fiscal management; 4) develop and use agency level performance measures; and 5) develop a new immunization registry. The Office of Family Health's Immunization Program is taking the lead for the immunization registry, and the Office is or will be involved in varying degrees with the other 4 priority areas. For instance, a fiscal management work group has been formed, and the Title V Federal Aid Administrator is a member of that group. This participation will facilitate the incorporation of block grant administration issues into the overall efforts of the agency. Working groups and action plans are still to be developed for the other priorities.

Overlaying these established agency priorities are a number of issues that emerged in FFY 2004 and continue to be of importance to the Health and Human Services System, including HHS R&L and the Office of Family Health. Child Protection Reform was initiated with the passage of LB 1089 in April 2004. This funding bill allocated $5.5 million for 120 new protection and safety workers, and another $350,000 for case coordinators. Additional funds were also made available for enhancements of the Criminal Justice Information System and other related activities. Then, during the 2005 legislative session, LB 264 was passed, which adds secondary prevention as a social service that may be provided on behalf of recipients under the Social Security Act. In addition, $200,000 per year was appropriated specifically for home visitation services.

The Office of Family Health is actively partnering with NE HHS Protection and Safety staff in addressing issues of child abuse prevention. Currently underway is the development of a child abuse prevention plan, described in more detail in Section IV B, State Priorities.

Also enacted in 2004 was enabling legislation for mental health reform. This law established the Behavioral Health Division within HHS and created a State Behavioral Health Council. The focus of this system reform effort has been to ensure statewide access to behavioral health services; ensure high quality behavioral health services; ensure cost-effective services; and ensure public safety and the health and safety of persons with behavioral health disorders. The immediate goal of the reform initiative has been the movement of behavioral health from institutional care to community-based services for persons with chronic and severe mental health disorders. In FFY 2005, the Nebraska Health and Human Services System has had the opportunity to do related work specific to children's mental health. Nebraska is the recipient of a 5-year, $750,000/year State Infrastructure Grant (SIG), awarded by SAMHSA, which is focusing on enhancing and building capacity for children's mental health services. Both the Offices of Family Health and Home and Community Based Services for

Aged and Physically Disabled (formerly Aging and Disability Services) have been actively involved in early activities of the SIG grant through participation in an internal stakeholders group.

Medicaid reform is the prioirty for HHS Home and Community Services Division. Nebraska has initiated Medicaid reform efforts in order to assess the current program and plan for the future. Legislation was passed (LB 709) that established the requirements for a Medicaid reform plan. This law requires that a plan be developed by December 1, 2005. As required by the law, the Governor and the chairperson of the Health and Human Services Committee have each designated a person to be responsible for the development of the plan. The Governor's designee is the Director of Health and Human Services Finance and Support; the Legislature's designee is the General Counsel of the Nebraska Legislature's Health and Human Services Committee. A Governor-appointed 10-person council will advise the process, and the Health and Human Services System will provide the staffing. The Title V/CSHCN Director is chairing a work team (Disabled Adults) and the Title V/MCH Director is a member of another work team (Children and Pregnant Women).

3. Process used to determine the importance, magnitude, value, and priority of competing factors upon the environment of health services in the State.

Section II, Needs Assessment, provides a comprehensive description of the processes used to determine Nebraska's MCH/CSHCN priorities. In addition, the Office of Family Health continues to draw upon the recommendations of a consultant that assisted the Department in 2001 in determining strategies for investment of Title V/MCH Block Grant Funds. This consultation was an important step in developing the framework for external allocation of Block Grant funds for the period beginning FFY 2003. This framework considered a variety of factors, including the availability of tobacco settlement funds to support local health departments and a concurrent need to support Tribal MCH efforts as part of a government-to-government relationship. This framework is being modified somewhat, but in essence will remain intact for external allocation of funds for FFY 2006 -- 2008.

In addition to these formal processes, the Office of Family Health has negotiated the demands of competing environmental factors by maintaining a focus on building its capacity to carry out the 10 essential public health services, both at the state level and at the community level. With flat or diminishing financial resources, it is clear that the Office and Title V cannot be all things for all people, nor can it pay for an extensive array of services. Rather, it is in our best interest to build public health capacity, and be aggressive in developing and maintaining a wide range of public health partnerships.

In this vein, the Office of Family Health completed an abbreviated version of the CAST-5 assessment in FFY 2005 (see Section II). During June 2005, the Office also participated in the application of the State Public Health Performance Standards. This latter activity will yield a state public health strategic plan, which in conjunction with our CAST-5 assessment, will provide the blue print for building capacity over the next few years. As a parallel activity, the framework for external allocation of Title V funds continues to include awards to local health districts for the development/enhancement of capacity to carry out the essential services as they relate to the MCH population.

4. Characteristics presenting a challenge to delivery of Title V services

Details are provided earlier in this section regarding a wide range of issues, including large geographic area, urban and rural differences, increasing diversity, racial and ethnic health disparities, an aging population, and special populations. These issues are ongoing challenges to the delivery of health and human services to Nebraska's MCH and CSHCN populations.

In recent years, Medicaid eligibility changes have been made in response to state budget shortfalls. As a consequence, thousands of low income children and parents no longer have Medicaid coverage. These reductions in coverage have and will continue to stress Block Grant funded services, particularly the Medically Handicapped Children's Program, which has long been a gap filler for those children not eligible under Medicaid. In addition, both federal and Nebraska lawmakers have expressed intent to further examine ways to reduce and/or control Medicaid expenditures. Nebraska's

Medicaid reform act requires that a plan be developed by December 1, 2005. One may assume that this plan may result in additional changes in either eligibility and/or covered services.

Health professional shortages have been a longstanding challenge for delivering MCH services across the state. Thirty-four of 93 counties are considered all or partially included in a Health Professional Shortage Area. The number of Federally Qualified Health Centers (FQHCs) has grown to 9, but these centers do not begin to address the vast distances some families have to travel to receive care.

Historically, Nebraska has been challenged in meeting match requirements for the Title V/MCH Block Grant at the state level, resulting in a significant dependence on local match sources. This situation will likely become more acute over time, as state general funds become scarcer and tobacco settlement funds are further diverted to other uses. At the same time, local match has usually included considerable amounts of Medicaid reimbursement as match. With fewer children now eligible for the program, that income will be reduced and thus negatively impacting local match (as well as the obvious disadvantage to children at risk). These compounding factors, though not a crisis this year, may become so in the future.

A more recent issue receiving attention in Nebraska and elsewhere is the aging of the public health work force. Success in carrying out the 10 essential public health services is dependent on an adequately trained work force. As many state and community level public health professionals retire in the next few years, the recruitment and retention of new public health workers is a concern. The relatively new MPH program, offered jointly by the University of Nebraska Omaha and the University of Nebraska Medical Center, addresses this need, in part. Non-competitive compensation and limited job advancement opportunities will continue to be a deterrent to recruiting new public health professionals, especially within state government.

In summary, Nebraska's greatest challenges in providing MCH/CSHCN services are: widely and unevenly dispersed populations; increasingly diverse populations; significant health disparities among racial/ethnic minorities; shortages of health professionals primarily in rural areas; diminished financial resources; and an aging public health workforce.

## B. AGENCY CAPACITY

With Title V/MCH Block Grant funding remaining flat and inflation increasing costs of doing business, maintenance of agency capacity to promote the health of all mothers and children, including CSHCN, has become increasingly challenging. As indicated in the previous section, investments in infrastructure and collaborative partnerships continue to be emphasized as the most efficient means for investing the Block Grant as a means of sustaining capacity.

Community level agencies have traditionally provided a number of services that encompass all levels of the public health pyramid. For the MCH population, services have included: home visitation; prenatal care; support services to at-risk pregnant women (particularly teens) and families with infants and children; "safety net" primary and preventive care services to children; and needs assessment and outreach activities for minority and newly arrived ethnic populations. For FFY 2006, $1.2 million in Block Grant funds are being made available for community level projects. Competitive applications were received July 1, 2005, with awards to be made by or about August 15, 2005. It is anticipated that these awards will be primarily for direct, enabling and population based services for pregnant women, infants, children, and CSHCN.

A separate Tribal set aside of $200,000 has been established for the four federally recognized Tribes headquartered in Nebraska. These funds may be used for either services or for infrastructure building. Then, to assure continued investment in community-level MCH infrastructure, $300,972 has been set aside for contracts with Nebraska's local health districts as recognized under NE LB 692.

State level programs receiving Title V/MCH funds that assure preventive and primary care services to pregnant women, mothers, infants, and children include the state's Perinatal, Child, and Adolescent Health Unit including school health, the MCH Epidemiology Unit (which includes the Child Death Review and PRAMS); Newborn Screening and Genetics; Office of Minority Health; Office of Women's Health; Dental Health; and Reproductive Health. In addition, the Block Grant provides partial support to the Birth Defects Registry.

Additional sources of revenue are continually being pursued to supplement state level MCH activities. Recent awards include a perinatal depression grant and a new newborn hearing screening grant. An allocation of TANF funds for home visitation ($200,000 year for 2 years) has also recently become available, providing a new source of funds for MCH services.

For CSHCN, one state-level program provides the majority of Title V-funded services to CSHCN -- the Medically Handicapped Children's Program (MHCP). Located in Home and Community Based Services for Aged and Physically Disabled, MHCP provides or pays for specialty and sub-specialty services through agency and contracted staff from a number of hospitals and private practitioners throughout the state. Many of these professionals participate in community-based multi-disciplinary team diagnostic and treatment planning clinic sessions, and they also offer medical care and follow-up medical services. Community-based medical home family physicians and pediatricians also provide follow-up services and care coordination throughout Nebraska.

In addition, MHCP operates the SSI-Disabled Children's Program (DCP) for those children eligible for SSI who are under age 16 and require rehabilitative and support services not otherwise provided by the Nebraska Medical Assistance Program (Title XIX, Medicaid). Services provided through the Nebraska SSI-Disabled Children's Program include: transportation to enable children to obtain diagnostic and/or treatment services, sibling care, attendant care,
respite care, meals and lodging while traveling to obtain medical care, personal care needs, utilities related to special high electrical use support equipment (e.g., nebulizers, oxygen concentrators, etc.), architectural modifications including wheelchair ramps, and specific items of equipment to maintain or improve functioning.

The Disabled Children's Program (DCP), which is a component of MHCP, provides funding to help families care for their children with disabilities at home. A family focused assessment process determines the need for services. Some of the funded services include: respite care; mileage, meals and lodging for long-distance medical trips; special equipment and home/architectural modifications; and care of siblings while care is received by the child with a disability/special need. The Disabled Children's Program (DCP) was designed to serve children who have a special health care need, receive monthly Supplemental Service Income (SSI) checks, are 15 years of age or younger, and live at home with their families.

In Nebraska, statutes pertaining to maternal and child health are found in Chapter 71, sections 2201-2208. The duties concerning the responsibility of the Nebraska Health and Human Services as to the federal early intervention program are found in 43-2509. Statutes requiring the birth defects registry are found in 71-645 through 648. Metabolic screening and associated responsibilities are found in 71-519 through 71- 524. Finally, CSFP is found at 71-2226 and WIC at 71-2227.

In 2003, LB 407 was signed into law which allocated $1,620,000 in tobacco settlement funds to the Lifespan Respite Services program for the biennium from July 1, 2003 through June 30, 2005. Use of this source of funds for respite care has allowed expansion of this service and has resulted in more MHCP funds being devoted to medical and rehabilitative services.

## C. ORGANIZATIONAL STRUCTURE

The Nebraska Department of Health and Human Services Regulation and Licensure (HHS R&L) is

now the State Title V/MCH agency. The Department is one of three agencies that form the Health and Human Services System. The other two agencies are the Department of Health and Human Services and the Department of Health and Human Services Finance and Support. LB 301, passed and signed into law in 2005, officially transferred Health Services, including the Office of Family Health and the administration of the Title V/MCH Block Grant, to HHS R&L.

Home and Community Based Services for Aged and Physically Disabled, including the Medically Handicapped Children's Program, have been administratively transferred to the Department of Health and Human Services Finance and Support (HHS F&S). Thus HHS F&S is now Nebraska's Title V/CSHCN Agency.

The Office of Family Health, HHS R&L, provides the principle oversight for administration of the Title V/MCH Block Grant. The MCH Planning and Support Unit reports to the Administrator for the Office of Family Health who is also the Title V/MCH Director. The unit includes the Federal Aid Administrator and an Administrative Assistant, for a total of 2.0 FTE. The MCH Planning and Support Unit is responsible for organizing and leading the development of the annual plan and report, administers sub-grants to communities, monitors allocations to other HHSS units and programs, and coordinates Title V funded activities with other public health programs within the Office and agency.

Other programs and units within the Office of Family Health include: Commodity Supplemental Food Program; WIC; Immunizations; Newborn Screening and Genetics (including Newborn Hearing Screening); Perinatal, Child and Adolescent Health (including school health, Early Childhood Comprehensive Systems, and Abstinence Education); Reproductive Health and the MCH Epidemilogy Unit (includes includes PRAMS, Child Death Review, and SSDI-supported activities.)

Special Services for Children and Adults has been changed to Home and Community Based Servcies for Aged and Physically Disabled in HHS Finance and Support. The Title V/CSHCN Director, who is also the co-director for Part C of the Individuals With Disabilities Education Act, is the Administrator for this office. Home and Community Based Services for Aged and Physically Disabled houses the following programs: Medically Handicapped Children's Program (MHCP), Home and Community-Based Medicaid Waiver for Aging and Disabilities, Katie Beckett Plan Amendment Services Coordination, Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, Adult Protective Services, SSI Disabled Children's Program, Nebraska Resource Referrals System, Genetically Handicapped Persons Program, Early Intervention Waiver, and Early Intervention and Medicaid in Public Schools Programs.

Early Intervention is co-administered with the Nebraska Department of Education.

Title V -- both MCH Planning and Support and MHCP -- maintain very collaborative relationship with the Medicaid program and Vital Statistics Management Unit, which are both located in the Finance and Support department, as well as the Data Management Unit in the Regulation and Licensure department. In addition, Title V works with a number of programs throughout NHHSS including: child care, juvenile services, mental health and substance abuse, developmental disabilities, minority health, health promotion and disease prevention, women's health, communicable diseases, dental health and rural health. Of these areas outside of Family Health and Aging and Disability Services, only minority health, data management, dental health, communicable diseases and women's health receive federal Title V funds. An organizational chart displaying the agencies and units is found as an attachment.

Health and Human Services System programs funded by the Federal-State Block Grant Partnership budget are described in the previous section. Community-based and Tribal programs supported by the Block Grant for the period of FFYs 2006 -- 2008 will be determined on or about August 15, 2005.

## D. OTHER MCH CAPACITY

As described earlier, the MCH Planning and Support Unit within the Office of Family Health has primary responsibility for the ongoing administration of the Title V/MCH Block grant.

Programmatic activities are carried out by various staff within the Office of Family Health. The Perinatal, Child and Adolescent Health Unit within Family Health is responsible for school health, adolescent health including abstinence education, child health, Healthy Mothers, Healthy Babies toll-free line, perinatal issues such as perinatal depression, and the Early Childhood Comprehensive Systems (ECCS) grant. This unit is staffed by 5.0 full time staff.

The MCH Epidemiology Unit was created in FFY 2004, and includes PRAMS, Child Death Review, and SSDI activities. It is staffed by 3.5 FTE and a 0.75 contract employee.

The Newborn Screening and Genetics Program staff is responsible for the oversight of Nebraska's newborn metabolic screening activities, genetics planning and development, and newborn hearing screening. It is staffed by 5.0 full-time employees and 1.0 temporary employee.

In addition to administering the Title X grant, the Reproductive Health Program carries out a wide range of activities related to women's and adolescent health and is staffed by 3.7 full-time employees.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental food, nutrition and health education, and related services through 14 local agencies across the state. The program currently serves over 40,000 participants each month. WIC has provided leadership in MCH nutrition activities, including breastfeeding promotion and support. The State WIC Director is Nebraska's representative to the Association of State and Territorial Public Health Nutrition Directors (ASTPHN). The program is staffed by 9 full-time FTEs, with and additional 2 information technology FTE permanently assigned to the program. The Commodity Supplemental Food Program serves an additional 14,000 individuals each month, the majority being seniors. This program is staffed by 1 full time FTE.

Also administered within the Office of Family Health, the Immunization Program manages CDC 317 and Vaccine for Children funds, and oversees public immunization clinics and the registry supporting these clinics. The program is staffed by 6.25 full time FTEs and a 1 temporary FTE

The Office of Family Health Administrator participates in a wide range of collaborative activities and initiatives described elsewhere. She is supported by a 0.2 FTE staff assistant. Paula Eurek, BS, RD, Title V/MCH Director, has been an employee of Nebraska Health and Human Services for 21years. Her maternal and child health experience includes two years of community-level experience as a WIC nutritionist and over 10 years as a state-level WIC nutritionist and administrator. Ms. Eurek assumed the roles of Administrator for the Office of Family Health and Title V/MCH Director in December, 1995. She had prior experience as the interim MCH Division administrator in 1988-1989. She is currently the Project Director for Nebraska's Integrated Comprehensive Women's Health Services in MCH Programs grant project, and provides general oversight to Nebraska's ECCS grant project and newly awarded perinatal depression grant.

In addition to administering MHCP, the Home and Community Based Services for Aging and Physically Disabled is responsible for a number of CSHCN services and activities. It partially funds the Answers4Families website which includes comprehensive information for families of children with special needs, school nurses, foster and adoptive families, and families, agencies and others concerned with children's mental health. The website also hosts discussion listservs (discussion groups for these populations). The website also includes information and internet listservs for other populations with special needs. This website also hosts the Nebraska Resource Referral System (NRRS) which includes over 8,000 social services type resources including child care, respite

coordinator information, medical/health and public health information, food pantries, etc. Addresses: http://www.answers4families.org and http://www.answers4families.org/nrrs/.

Also, the Home and Community based Services for Aged and Physically Disabled is a Co-Lead for Part C of the Individuals with Disabilities Education Act along with the Nebraska Department of Education, Special Populations. Consequently, the Family Partner full time position represents families for both the Early Development Network programs and the CSHCN programs. The Family Partner attends CSHCN training for CSHCN staff, national MCH/CSHCN meetings and is a member of advisory groups to the CSHCN Program. The CSHCN Nurse Consultant staff member has been a family member of a CSHCN in the past but this currently is not the situation.

Mary Jo Iwan, BA, Title V/CSHCN Director, has been an employee of Nebraska Health and Human Services for 32 years. She has extensive experience working in programs to serve persons with disabilities, as well as broader based programs such as the Social Services Block Grant. Ms. Iwan assumed the role of Title V/CSHCN Director in 1991. She is actively involved in a number of Governor-appointed organizations, including the Developmental Disabilities Council and the Governor's Task Force on Alzheimer's Disease and Related Disorders. She is also involved in activities at the national level, including membership on the Health Care Financing Administration (HCFA) Non-Institutional Long-term Care Technical Assistance Group and HCFA Home and Community Quality Work Group.

## E. STATE AGENCY COORDINATION

Examples of State Agency Coordination specific to Title V/CSHCN include MHCP involvement in a Federal Centers for Medicare and Medicaid Services (CMS) System Change Grant (Portals to Adulthood) to develop protocols an processes around transition youth with disabilities to adult medical services by working with existing MHCP clinics and physicians with the University of Nebraska Medical Center. In addition this project incorporates Nebraska Easter Seals, Department of Education, and local HHS workers to expand the transition plan to include a medical component, ensuring appropriate medical care for Nebraska's low income disabled children.

Nebraska HHSS is part of a coordinated funding committee that encompasses Vocational Rehabilitation, MHCP, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral Palsy, the Disabled Persons and Family Support Program, and other private non-profit programs to assure that individuals receive services for which they are eligible. This committee of providers and advocates has met to discuss individual care plans and find solutions which make the most efficient use of program resources for the past eighteen years.

The Disabilities Determination Unit (DDU) for Social Security and SSI is located in the Nebraska Department of Education. The DDU sends notification to MHCP on a regular basis of children determined eligible for SSI, at which time MHCP sends a notice to the family describing possible services they may receive and how to apply. This relationship ensures that families receiving SSI for their children are notified of their potential eligibility for services.

With the administration of Nebraska's Title V/MCH Block Grant located within the Office of Family Health, abundant opportunities exist to coordinate Block Grant investments with a wide range of MCH programs and activities funded through other sources, including WIC, CSFP, Immunizations, and Reproductive Health. Then, with the Office of Family Health being in the same branch of HHS R&L with the Offices of Rural Health, Minority Health, Women's Health, Public Health, and Disease Prevention & Health Promotion, another and even more significant level of collaboration opportunities exist. References to these collaborative efforts are found throughout this application.

Within the larger Health and Human Services System, the Office of Family Health has ongoing and active partnerships with Child Care Subsidy, Child Care Licensing, and Protection and Safety. It has

expanded its collaboration with Behavioral Health, in conjunction with the Mental Health Component of the ECCS grant, the SAMSHA SIG project, and the newly awarded perinatal depression grant.

The Nebraska Department of Education (NDE) is an active partner with the Office of Family Health in carrying out early childhood programs and initiatives, including ECCS. The Title V/MCH Director is reciprocally active in the NDE's Early Childhood Policy Initiative, the development of Early Learning Guidelines, and administration of the statutorily required READY Act (early learning materials for all Nebraska newborns and their families).

Nebraska Title V has a long-standing working relationship with the state's urban health departments. Both the Douglas County Health Department and the Lincoln/Lancaster County Health Department currently receive Title V funds for specific activities, but each have been partners in a wide range of initiatives. For instance, representatives of the Douglas County Health Department actively participated in the recently completed needs assessment and are active in current projects such as Safe Sleep. A staff person with the Lincoln/Lancaster County Health Department (LLCHD) also participated in the needs assessment process and has been active in the Breastfeeding Initiative.

Nebraska Title V also works with smaller local health departments and other community health agencies, both as a funder and a collaborator. As previously stated, $300,072 has been set aside for contracts with Nebraska's LB 692 designated local health districts for the purposes of building and sustaining MCH infrastructure. In addition, as the newer local health districts have matured, their staff has become increasingly engaged in state-level activities and initiatives, such as Safe Sleep and Breastfeeding Promotion and Support.

Nebraska's federally qualified health centers continue to be key partners in serving the MCH population. The Charles Drew Health Center, through its Healthy Start program, provides enabling services to the perinatal population of northeast Omaha. The Office of Family Health works whenever possible to connect state level activities with Omaha Healthy Start. In addition, Hope Medical in Omaha, a Nebraska Title V funded project, subcontracts with Charles Drew Health Center for selected services. Similarly, Panhandle Community Services, the location of the FQHC in western Nebraska, has been a subcontractor for the Panhandle Partnership's Title V project.

Local health departments, federally qualified health centers, and applicable Title V supported community projects are key partners in assuring that pregnant women access prenatal care and help identify pregnant women and hcildren elibile for Medicaid services. In turn, Medicaid presumptive elibility for pregnant women continues to be determined by many of these providers.

Nebraska Title V continues its working relationship with the Primary Care Office by sharing data and information. The Primary Care Office assisted with geocoding as part of the comprehensive needs assessment.

Nebraska Title V works closely with a number of programs and departments within the University of Nebraska Medical Center (UNMC). The Munroe-Meyer Institute is a close collaborator on a number of CSHCN projects. A new relationship was established with the University of Nebraska ---Omaha, for the CSHCN component of the comprehensive needs assessment. Many other working relationships exist with various faculty and staff throughout Nebraska's university systems, including development and support of internet-based services for families of CSHCN and for school nurses.

Nebraska has a relatively young Masters in Public Health program, a combination degree program sponsored by the University of Nebraska Medical Center and the University of Nebraska at Omaha. The MPH program finished its first semester in operation in May, 2002, and since has acquired accreditation. This program, along with the newly established Great Plains Public Health Leadership Institute, provide opportunities for collaborations around staff development and building public health capacity.

Collaborations were expanded during FFY 2004 through Together for Kids and Families, Nebraska's

State Early Childhood Comprehensive Systems project, including HHSS and Department of Education staff working with program and services for homeless students and families. In addition, Office of Family Health are actively working with Medicaid Managed Care staff on a prenatal care quality improvment project.

An ongoing project that has depended on a close partnership with the Nebraska Department of Education is implementation of the READY Act. This act, passed by the Legislature in 2002, requires that materials be provided to the parents of all infants born in Nebraska that promote early learning opportunties and healthy, safe child development. The Title V/MCH Director was the lead HHSS contact for this project, and helped coordinate the health and safety content of the materials and planned for the distribution. The Department of Education took the lead in the overall design and production. A Title V/MCH funded project field tested the materials with young parents. The booklet, "First Connections with Families" was completed late in 2003, and distribution started in January 2004. The Perinatal, Child and Adolescent Health Unit is responsible for ongoing distribution. Participating hospitals distribute to new parents, while other parents receive via the mail 3-4 months after birth.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

#01HSCI The rate of children hospitalized for asthma (10,000 children less than five years of age).

Nebraska HHS R&L contracts with the Nebraska Hospital Association for hospital discharge data and 2004 data is unavailable at this time. Nebraska's rate significantly increased in 2003 after showing little change from 1999 (15.3) through 2002 (15.9/10,000).

#02HSCI The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

Nebraska has historically done well on this indicator, from a rate of about 75% in 1997 to nearly 100% in 2003. However, this indicator decreased to 81.7% in 2004.

In general Medicaid Title XIX enrollment for all children is down. By June of 2004 the number of children eligible for Medicaid had decreased by more than 25,000 since the all time high in October of 2002.

#03HSCI The percent of SCHIP enrollees whose age is less than one year whose age is less than one year who received at least one initial periodic screen.

In 2004 this indicator shows significant improvement in both the number eligible and the percent screened. The data in this indicator is a sub-set of indicator #02HSCI so, while the overall Medicaid infant population receiving at least one periodic screen decreased those infants who were SCHIP eligible increased.

In general SCHIP (Title XXI) eligibility for all children is up. By June of 2004 the number of children eligible for SCHIP had increased by more than 15,000 since the all time high in since June 2000.

#04HSCI The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.

This indicator has remained in the 70% range from a low of 71.7% (2000) to a high of 76.9% (1997). Currently the indicator shows 76.2% receiving adequate prenatal care on the index, the highest is has been since 1998.

Details of Nebraska's activities surrounding prenatal care are found under National Performance Measure #18. Approximately one-third of Nebraska's deliveries are paid by the state's Medicaid program so data is not independent of trends in Medicaid. This indicator is also impacted by racial

and ethnic disparities in access to care and insurance status. State Performance Measure # 14: the percent of African American women beginning prenatal care during the first trimester helps Nebraska to track racial disparities.

#05HSCI no longer required

#06HSCI no longer required

#07HSCI The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

This indicator has mixed success in Nebraska. However, with changes in Medicaid/SCHIP eligibility, the overall number of EPSDT eligible children will decrease. Furthermore, children's orthodontics coverage has been limited through legislative cuts to Medicaid to cases involving craniofacial birth defects affecting the occlusion and mutilated and severe occlusion cases only. Nebraska continues to have trouble recruiting and retaining Medicaid dental providers. The Office of Family Health in partnership with the Dental Division, are working with UNMC's Department of Pediatric Dentistry and the Association of State and Territorial Dental Directors (ASTDD) has implemented Nebraska's first-ever open-mouth oral health survey. Preliminary results are currently available and a full report will be published in the fall of 2005.

#08HSCI The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN program.

Denominator of 3165 is taken from table 7 produced by SSA, SSI Record, 10 percent sample of December 2003 of number of children in Nebraska receiving federally administered SSI payments of children under the age of 16 years. Numerator is taken from the CONNECT computer system and number choosing to obtain Respite services from the Lifespan Respite Subsidy Program instead of the CSHCN funding source totals a numerator of 938. This equals 29.6%. This is a percentage somewhat lower than expected. It is noted however, that all SSI eligible children referrals received from the Nebraska Department of Education, Disability Determinations Section (a) are not counted/entered into the computer system by MHCP (CSHCN) (b) until the family has decided to seek benefits from one of the MHCP programs and that (c) MHCP may not provide benefits some families require. These factors and the presence of SCHIP benefits (Kids Connection in NE) serving more children have acted to lower CSHCN counts.

#09(A)HSCI The ability of States to assure that the MCH program and Title V agency have access to policy and program relevant information and data.

Nebraska now has the ability to perform an annual linkage of birth certificates and Medicaid eligibility or Paid Claims Files and is now working on incorporating the linkage with WIC files. Nebraska has just complete the 2003 birth file linkage with Medicaid file as the 2004 birth file is not cleaned.

In January 2005, Nebraska implemented the NCHS 2003 birth certificate format and electronic filing which provides a check-off box for both Medicaid and WIC participation. However, linkage reports for 2004 will be forthcoming.
For many years, Nebraska has used a linked birth and infant death file, and a linkage of birth and newborn screening files. Nebraska has a contract with the Nebraska Hospital Association for hospital discharge data. Due to the nature of the contract, 2004 data is unavailable at this time. Discussion to enable NHHSS to obtain limited identifiers from this dataset for the purpose of linkage with other datasets remains on-going, but has yet to yield results.

Nebraska has had a birth defects registry system since the early 1970's. It recently received a grade of "B". NHHSS was unsuccessful in a bid for grant monies in 2004 to enhance the system, but continues to seek funding that would enable the system to move from a reactive system, to a proactive system.

Nebraska has an excellent PRAMS project that has received national attention for its high completion rates. Begun in 1999, the project has published two data reports, and an oral health analysis. Work is underway on analysis of Douglas County (largest urban community) data representing nearly half of the births in Nebraska. Nebraska PRAMS is conducted yearly.

See #09(B)HSCI for details of YRBSS. Nebraska engages in all three of these data sources.

Funding is provided by the State Systems Development Initiative (SSDI) Grant, in partnership with Tobacco Free Nebraska, for a number of youth-related surveys and reports: 2003 Youth Risk Behavior Survey" (December 2004); "Data and Trends on Tobacco Use in Nebraska" (May, 2004); 2002 NE Middle School Youth Tobacco Survey (October 2004); and 2002 NE high School Youth Tobacco Survey (October 2004).

SSDI will continue to support the YRBS. An electronic database will be available in 2005 for the first time, enabling Nebraska to perform further analysis. YRBS continues to be hampered by lack of participation from Nebraska's largest school district, Omaha Public Schools (OPS).

Despite repeated attempts to collaborate with the OPS School Board, OPS was not included in the 2005 YRBS. Negotiations will continue again for 2007. Without OPS participation, YRBS results are not truly representative of a statewide population and no racial/ethnic data is available. YRBS is performed every other year in Nebraska.

The Adolescent Health Program in the Office of Family Health has developed a series of 10 fact sheets highlighting the 2002 School Health Education Profile (SHEP) data and 2003 YRBS data. These fact sheets describe the behaviors of Nebraska students (YRBS) and then SHEP data that describe what schools are doing in terms of their instructional programs, their policies, and their in-service activities. Topics covered on the fact sheets include: tobacco, nutrition, physical activity, violence/safety, sexual activity/STDs, alcohol and coordinated school health model. MCH/Title V funds support this project.

The Office of Family Health was part of a team headed by the Nebraska Injury Prevention Project (Office of Health Promotion and Disease Prevention) that published two reports during the Summer of 2004: Safe Kids and Pediatric Falls. Primary funding for these projects is through CDC's Injury program, however, supplemental funding is from the State Systems Development Initiative (SSDI) Grant.

Finally, the Office of Family houses the Child Death Review Team (CDRT) coordinator. In the past year a review and report to the Governor on the occurrence and classification of the first three months of SIDS deaths in 2005 was produced. CDRT was also instrumental in providing data for an Office of Family Health Safe Sleep Initiative currently in process. Funding for the CDRT is mostly provided by the Title V/MCH Block Grant, with supplemental funding from the State Systems Development Initiative (SSDI) Grant.

#09(C)HSCI The ability of States to determine the percent of children who are obese or overweight.

In 2004 Office of Family Health was part of a team headed by the Nebraska Cardiovascular Health Program (Office of Health Promotion and Disease Prevention) that published the "Overweight Among Nebraska Youth 2002/2003 Academic School Year".

## IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

### A. BACKGROUND AND OVERVIEW

The investment of Title V funds in Nebraska is driven by a number of key factors. The first set of factors is the MCH/CSHCN priorities identified through the needs assessment completed in 2005. These priorities will guide funding decisions for FFY 2006 and beyond. A second important factor was the technical assistance consultation provided by Donna Petersen in 2001. This consultation provided recommendations for how to balance investments in infrastructure and local services. Next, Nebraska's emerging local health districts, supported through tobacco settlement funds, have offered a unique opportunity for building MCH capacity. Finally, though the State's financial status is not as gloomy as in recent years, fiscal constraint is still needed.

Between 2000 and 2003, Medically Handicapped Children's Program applications have more than tripled. Going from 132 in 2000 to 580 in 2003, yet the available funding has stayed the same. We continue to balance between the rising need and the stagnant funding to meet the increasingly complex medical needs of CSHCN.

Thus, decisions on the allocation of Title V funds continues to be a balance between meeting the needs of the MCH/CSHCN populations, capitalizing on opportunities to build infrastructure, and sustaining basic, ongoing services in a time of limited financial resources. Even more than in previous years, collaboration with other programs and integration of financial resources is critical to address priorities. In this regard, it must be pointed out that the term Title V Program does not capture the essence of the work carried out through Title V in Nebraska. For both the MCH and the CSHCN populations, the integration of resources, both financial, human and logistical, is key to addressing priority needs. Title V funds are being increasingly invested in basic infrastructure, with the support of other health and human services programs augmenting interventions.

### B. STATE PRIORITIES

Nebraska completed its most recent comprehensive needs assessment in 2005. Ten priority needs were identified. Below is a description of each priority need, NE's capacity and resource capability to address each, and relationships to national and state performance measures. It must be noted that community-based projects addressing priority needs will NOT be known until on or after August 15, 2005. Mid and long range planning for state-level strategies will be initiated early in FFY 2006.

1. Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.

Following national trends, increasing rates of overweight was identified as a priority need across all MCH populations. Taking the lead in addressing this need has been Nebraska's Cardiovascular Health Program. In collaboration with the Office of Family Health's School and Child Health Nurse Coordinator, the Cardiovascular Health Program collected and analyzed BMI data for 40,154 students in K-12 from 235 schools for the 2002/2003 academic school year. The study report, published in June 2004, provided excellent baseline data for the assessment of overweight among Nebraska children as part of the recent needs assement. In addition, the Cardiovascular Health Program led the development of the Nebraska Physical Activity and Nutrition State Plan, released in April 2005. This plan lays out a comprehensive set of goals, strategies and objectives to be used for intra and interagency collaborations for the next 5 years. The Office of Family Health has taken the lead in addressing the objective for increasing supports for breastfeeding, through an initiative that was launched in January 2005. The Office will continue to work with both the Cardiovascular Health Program and the Office of Women's Health in promoting VERB(r) and will help the Cardiovascular Health Program launch the Youth Physical Activity and Nutrition Lifestyle Modification Rx for use in both school and health care settings.

Of the National Performance measure, only NPM #11, percentage of mother who breastfeed their

infants at hospital discharge, relates in any way to this priority needs. Thus, a new State Performance Measure # 1 has been chosen for 2006: percent of women (18-44) with healthy weight.

2. Reduce the percent of women of child-bearing age, particularly pregnant and post-partum women, and adolescents who use tobacco and reduce the percent of infants, children and youth exposed to second hand smoke

Tobacco use and exposure to second hand smoke were identified as significant factors impacting a wide range of health outcomes for MCH populations. Nebraska has a strong Tobacco Free Nebraska program that has been an ongoing partner with the Office of Family Health. In 2002 and 2003, in collaboration with Tobacco Free Nebraska, the Office of Family Health developed tobacco cessation materials for women of child bearing age and their health care providers. In addition, Family Health subgranted funds to community-based organizations to develop local capacity for perinatal tobacco cessation efforts. These materials and the subgranting efforts were financed with tobacco settlement funds. The Office of Family Health will continue to build on this working relationship with Tobacco Free Nebraska in promoting tobacco prevention and cessation. For instance, Family Health is participating in the development of a tobacco cessation state plan, being lead by Tobacco Free Nebraska.

No National Performance Measures relate to this priority need. Nebraska therefore has selected for 2006 SPM # 2, percent of women of child --bearing age who report smoking in the past 30 days.

3. Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.

In order to improve overall outcomes for infants, this cluster of events was identified as a priority need. Nebraska Title V/MCH Block Grant funds have long invested in services for pregnant women, including adolescents. These services range from prenatal care, to home visitation, to outreach and translation services. It is anticipated that such services will again be included in the array of local projects funded in FFY 2006 through FFY 2008. In addition, the Office of Family Health has and will continue to work with local initiatives, such as "Baby Blossoms" in Omaha/Douglas County, and its member programs, such as Omaha Healthy Start. In addition, the Office continues to work with the Medicaid Managed Care program on a prenatal care quality improvement initiative. Yet much more needs to be accomplished, particularly related to pre and interconception risks. As identified by Omaha's Baby Blossoms members using Perinatal Periods of Risk methodology, maternal health is key to improving birth outcomes. Over the next year, additional strategy development and partnership formation will be pursued to build capacity in this area.

National Performance Measures #15, percent of very low birth weight infants, #17, percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, and #18, percent of infants born to pregnant women receiving prenatal care beginning in the first trimester all relate to this priority need. In addition, SPM #5 has been selected for 2006, percent of premature births, and SPM #6, rates of infant death to adolescent mothers (age 15-17).

4. Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.

This priority was also identified in the 2000 needs assessment, with unintentional injuries being the major cause of morbidity and mortality among Nebraska children. Nebraska's capacity to address this issue has its leadership within the Nebraska Injury Prevention Program, Office of Disease Prevention and Health Promotion. This program has long fostered and supported Safe Kids coalitions across the state, and has a strong motor vehicle safety component. The program also plays a key role in monitoring and analyzing injury data, releasing the Nebraska Injury Surveillance Report in August 2004. In addition, Nebraska's Emergency Medical Services for Children program has been an active provider of injury prevention information across the state. The Office of Family Health will continue its close working relationship with these programs, and pursue new endeavors. For instance, the Office of Family Health is leading a Safe Sleep initiative, and both the Injury Prevention Program and EMSC

staff are participating in this effort.

National Performance Measure #10 will be useful in measuring progress in reducing motor vehicle associated injuries. In addition, a new SPM #9 has been chosen for 2006, hospitalization for unintentional injuries (per 1000,000) for children and adolescents (age 1-19).

5. Reduce the number and rates of child abuse, neglect, and intentional injuries of children.

Intentional injuries were combined with unintentional injuries as a priority need identified through the 2000 comprehensive needs assessment. The identification of prevention of child abuse, neglect and intentional injuries as a separate priority in 2005 marks a major shift for public health in Nebraska. Abuse and neglect, as well as youth suicide and homicide, have traditionally been seen as child welfare, behavioral health, and criminal justice issues. As a priority for MCH, new opportunities emerge for primary and secondary prevention efforts. Over the next several months, the Office of Family Health will be working with the HHS Protection and Safety, Prevent Child Abuse Nebraska, and the Foundation for Children and Families in developing a child abuse prevention plan. Development of the plan will include an analysis of best practices and engagement of community stakeholders. Concurrently, Nebraska's Injury Prevention Program is working with other stakeholders to develop plans related to youth suicide prevention. These and other collaborative efforts will add significantly to our state's capacity to address this priority.

National Performance Measure # 16, rate of suicide deaths among youth aged 15 -- 19, relates to this priority, but does not provide a measure of child abuse and neglect. Therefore SPM # 10, has been selected, hospitalizastion for intentional injuries (per 100,000) for children and adolescents.

6. Reduce the rates of infant mortality, especially racial/ethnic disparities.

This need was also an identified priority in 2000. Though overall infant mortality rates have shown some improvement over the past 5 years, there is still work to be done to meet 2010 objectives and much more work to eliminate racial/ethnic disparities. The work and capacity development described for Priority Need #3 above is also relevant to this priority. In addition, a continued focus will be maintained on postneonatal deaths, particularly sleep associated infant deaths. The Safe Sleep Initiative, launched in April 2005, has brought together a wide range of stakeholders to develop a shared understanding of sudden, unexpected infant deaths, and members of the initiative's steering committee are currently developing a report of recommendations on prevention messages and system strategies. This state level effort will coordinate closely with that of Baby Blossoms, the Omaha area perinatal collaborative.

No National Performance Measure provides an adequate gauge of progress, particularly related to disparities. Therefore SPM # 7, incidence of confirmed SIDS cases (per 1000 live births) among African American and native American infants, and SPM #8, percent of African American women beginning prenatal care during the first trimester, have been selected for 2006.

7. Reduce alcohol use among youth.

Youth alcohol use was combined with tobacco and other drug use as a priority need in 2000. The separate identification of alcohol use as a high risk behavior among Nebraska youth highlights its contribution to a wide range of poor health outcomes, including motor vehicle injuries and mortality. The Office of Family Health had been an active partner in the State Incentive Cooperative Agreement (SICA), a state/federal parentership to reduce substance abuse amongh youth ages 12 to 17. But much of the collaborative work thus far has focused on identifying risk and protective factors among Nebraska youth. Much needs to be done to develop public health capacity for alcohol prevention. We can learn from successes achieved through Tobacco Free Nebraska, but an ongoing challenge will be garnering enough resources to invest in this effort. Identifying key partners will be a major initial step in building this capacity.

None of the National Performance Measures relate to this need. A SPM that Nebraska has been tracking the past 5 years will be continued as SPM # 4 in 2006, percent of teens who report alcohol use in the past 30 days.

8. Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.

Key to the identification of this priority was the CSHCN SLAITS data for Nebraska, which revealed access to behavioral health services to be a significant problem for special needs children and their families. This observation, along with the NE HHS System's extensive work in behavioral health reform, places behavioral health among Nebraska's MCH/CSHCN priorities for the first time. Nebraska's capacity to address this need will be significantly improved through multiple efforts underway, including: the strategic plan being developed as part of Nebraska's Early Childhood Comprehensive Systems grant; the SAMHSA-funded State Infrastructure Grant; and the recently awarded perinatal depression grant.

NPM # 16, rate of suicide deaths among youth aged 15 -- 19 offers a limited measure of progress in addressing this need. To further assess our work, SPM # 3 has been selected, percent of women (age 18-44) who report mental health not good 10+ days of past 30.

9. Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.

In this time of increasing cost of medical services it is difficult to increase the number of families served without increased finances. We are maintaining our services. As Medicaid reform continues we may see a need to tighten or limit the number of clinics or services we are able to provide.

National Performance Measure #4, percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for services they need, is directly related to this priority.

10. Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.

Through a federal Centers for Medicare and Medicaid Services System Change grant, Nebraska will develop and pilot transition medical and dental clinics for youth with special health care needs. The clinics will incorporate education for resident physicians on the disability related medical conditions that will advance as the youth ages to adult medical care. This will increase the number of physicians familiar with special health care needs and increase the number of knowledgeable physicians in communities to provide a "medical home."

National Performance Measure #6, the percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life, is directly related to this priority.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual** | | | | | |

| Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 99.6 | 99.7 | 99.6 | 99.8 | 100.0 |
| Numerator | 24863 | 25043 | 25478 | 26008 | 30 |
| Denominator | 24958 | 25109 | 25575 | 26067 | 30 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2002**

1998-2001 data refers to guidance effective through April 20, 2003, which requires a slightly different data than the 2002 + indicators. Therefore, comparison of indicators from 1998-2001 & 2002 + is not possible.

**Notes - 2003**

1998-2001 data refers to guidance effective through April 20, 2003 which requires a slightly different data than the 2002 + indicators. Therefore, comparision of indicators from 1998-2001& 2002 + is not possible.

**Notes - 2004**

At annual review (8/10/05) Nebraska was asked to report of those who were screened how many received follow-up. In the past years Nebraska had been reporting those screened/live births. Therefore the data will not be comparable.

## a. Last Year's Accomplishments

The Nebraska Newborn Screening & Genetics Program managed mandated screening for 6 diseases (Biotinidase Deficiency, Congenital Primary Hypothyroidism, Galactosemia, Hemoglobinopathies MCAD & PKU) during this reporting period, and universal (offered to every newborn, but consent required) for another approximately 30 amino acid, organic acid and fatty acid disorders, via the "supplemental" screen.

Effective July 1, 2003 all newborn specimens from Nebraska newborns were sent to Pediatrix. As a result of a negotiated rate of $30.75 for testing and NBS fee (mandatory only, or mandatory plus supplemental) many more parents opted for the additional supplementary panel of disorders screened by tandem mass spectrometry. Greater than 96% of newborns now benefit from the full amino acid and acylcarnitine profiles provided at Pediatrix Screening Laboratory.

Using mostly fees collected for each infants newborn screen, the program funded metabolic formula and foods, dietitian consultation and part of an FTE for a Pediatric Metabolic Specialist to assist the program with initial follow-up communication with newborns' medical homes.

The numbers screened can only be reported by calendar year. In 2004 Nebraska had 26431 births reported (preliminary numbers) to the Newborn Screening Program (preliminary numbers) of which 26,380 were screened. Fifty one not screened expired by 48 hours of birth. Approximately 96.35% of newborn's parents consented to and their newborns received the

supplemental screen . Fifty five home births were reported to the program and all were screened. Newborns with disorders were identified and treated early with: 6 newborns with partial biotinidase deficiency; 8 with congenital primary hypothyroidism;3 duarte variant galactosemias; 1 sickle hemoglobin C disease and one with hemoglobin C disease; 4 babies with MCAD; 1 with classical PKU and 5 with hyperphenylalaninemia (3 hyperphe's tx'd) plus 2 with 3-MCC on the supplemental screen (3-methylcrotonyl-CoA Carboxylase Deficiency).

In response to the American College of Medical Genetics report to the Secretary of HHS's Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children the Nebraska Newborn Screening Advisory Committee began to exam recommendations for adding certain disorders to the screening panel. Work groups recommended adopting the 2 disorders (Cystic Fibrosis and Congenital Adrenal Hyperplasia) from the uniform panel into Nebraska's required screening panel.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Screen, refer, track, & facilitate treatment for 6 disorders as per Neb. Rev. Stat. 71-519 to 524 | | | X | |
| 2. Continue quality assurance activities with hospitals, contracted laboratory, and referral networks. | | | X | |
| 3. Finalize and implement new regulations adding Cystic Fibrosis and Congenital Adrenal Hyperplasia as required disorders | | | X | |
| 4. Provide professional and parent education, including maintenance of web site. | | | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The Newborn Screening and Genetics Program continues to screen for the 6 required disorders with supplemental screening offered to all families. Follow-up, referral and treatment activities continue as described for FY 2004. The Newborn Screening web pages were updated, and can be found at http://www.hhs.state.ne.us/nsp/

As noted for last year's activities, work groups recommended adopting the 2 disorders (Cystic Fibrosis and Congenital Adrenal Hyperplasia) from the uniform panel into Nebraska's required screening panel. The Newborn Screening Advisory Committee forwarded these recommendations to the Department in FFY 05. The HHSS Policy Cabinet accepted these recommendations, and a revision of the regulations is in process, with a public hearing held in FFY 2005. To handle the additional anticipated workload, a Family Health staff member's work was reassigned to assist with the follow-up functions critical to a successful newborn screening system.

c. Plan for the Coming Year

FFY 2006 activities will focus on the addition of Cystic Fibrosis (CF) and Congenital Adrenal Hyperplasia (CAH) to the screening panel. It is anticipated the revised regulations will be finalized early in FFY 2006, with screening for the 2 disorders beginning January 2006. In addition to the work on the regulations, implementation activities will include: developing confirmatory testing and diagnostic referral systems and protocols; internal notification and tracking protocols; education for health care professionals about the additional screening requirements; revision of patient information materials; revision of the screening laboratory contract; and coordination with the laboratory on reporting issues.

Additional activities, also related to the new disorders, will be developing partnerships and collaborations between genetic counseling providers and laboratories conducting confirmatory sweat testing, the Certified CF Center and pediatric pulmonology providers, and pediatric endocrinology providers at different institutions.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 70 | 0 | 70 |
| Annual Indicator | | | 66.4 | 66.4 | 66.4 |
| Numerator | | | 326 | 326 | 326 |
| Denominator | | | 491 | 491 | 491 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 70 | 70 | 70 | 70 | 70 |

**Notes - 2002**

Only 2002 data available.

**Notes - 2003**

2003 data unavailable. Used 2002

**Notes - 2004**

Data is unavailable for 2004. Used 2002.

a. Last Year's Accomplishments

Nebraska's CSHCN Program continued ongoing activities to support of this performance measure during this past period. A description of family-centered services follows.

A services coordinator/social services worker is assigned to help families access services to fit their needs and those of the child with a disability or chronic health care need. Help is provided to identify services that may be needed, referral and access to these services, and assistance in locating payment sources. The worker is also the family's link into the medical team evaluation and treatment planning process through specialty clinics for children and youth.

The Program provides access to specialty evaluations that provide a diagnosis and medical treatment plan prior to the family making a financial application. The evaluations may be provided with select specialty providers and/or one of the specialty clinics for children and youth.

Specialty clinics for children and youth are teams which consist of specialty physicians, nutritionists, nurses, occupational therapists, physical therapists, psychologist, dentists, speech and hearing pathologists, and the family. The teams meet all at one time and in one place. Team membership depends upon the particular medical conditions being reviewed. The most important member of the teams is the family. Teams provide diagnosis of the medical concerns and problems, a written plan of treatment, and access to all the team members at one time and place.

The family is able to carry a list of written recommendations home from the team clinic. Copies of the complete report and plan are provided to service providers and school systems as authorized.

In addition during FFY 2004, Services Coordinators were trained on Coaching methods regarding family centered approaches to service delivery. This event was done in collaboration with the activities of the Center for Medicare and Medicaid Services (CMS) System Change Real Choice grant where over 200 Services Coordinators and supervisors began training

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Services coordinator/social services workers assigned to help families access services | | X | | |
| 2. Provide access to specialty evaluations that provide a diagnosis and medical treatment plan prior to the family making a financial application | X | | | |
| 3. Continue multi-disciplinary specialty clinics for children and youth. | | | | |
| 4. Incorporate medical transition from pediatrics to adult physicians as component of the IEP for youth with special health care needs as well as students not identified as having an IEP but with special health needs. | | X | | |
| 5. Provide training on family centered approaches to Services Coordinators using a web-based curriculum. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Services Coordinators were trained on Coaching Methods regarding family centered approaches to services delivery. This event was done in colalboration with the activities of the Center for Medicare and Medicaid (CMS) System Change Real Choice grant where over 200 Services Coordinators and supervisors began training.

### c. Plan for the Coming Year

To ensure new Services Coordinators are trained in the same manner with the coaching principles, a web based training curriculum is being developed. The training will be placed on the web and available for new hires or as a refresher for current staff. Nebraska is assisting families with the transition of their adolescent children to adult medical services through a federal EPSDT Portals to Adulthood grant.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 55 | 0 | 55 |
| Annual Indicator | | | 53.8 | 53.8 | 53.8 |
| Numerator | | | 706 | 706 | 706 |
| Denominator | | | 1313 | 1313 | 1313 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 55 | 55 | 55 | 55 | 55 |

**Notes - 2002**

Only 2002 data available.

**Notes - 2003**

2003 data unavailable. Used 2002

**Notes - 2004**

Data is unavailable for 2004. Used 2002.

### a. Last Year's Accomplishments

Nebraska completed additional training to Services Coordinators regarding what constitutes a "Medical Home," how to rack one, and the importance of each CSHCN to have one.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| | **Pyramid Level of** |
|---|---|

| Activities | Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Develop medical homes through transition clinics and add medical component to IEP for students in special education | | X | | |
| 2. Implement medical home plan through transition grant, including training for families, students, physicans and school nurses. | | X | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Home and Community Services MHCP is currently working colaboratively with the Federal grant received in developing a medical home through transition clinics and adding a medical compoent to their IEP for students in Special Education.

c. Plan for the Coming Year

We will implement the "Medical Home" plan through the grant mentioned above. This will include training for families, students, physicians and school nurses. We will continue to be involved.

In addition, the strategic plan being developed through the State Early Childhood Comprehensive Systems grant (SECCS) will yield some broad strategies that will further promote the medical home concept for all children, including CSHCN.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 65 | | 65 |
| Annual Indicator | | | 63.5 | 63.5 | 63.5 |
| Numerator | | | 719 | 719 | 719 |
| Denominator | | | 1133 | 1133 | 1133 |
| Is the Data | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 65 | 65 | 65 | 65 | 65 |

**Notes - 2002**

Only 2002 data available.

**Notes - 2003**

2003 data unavailable. Used 2002.

**Notes - 2004**

Data is unavailable for 2004. Usewd 2002.

a. Last Year's Accomplishments

Ongoing activities to increase the numbers of children with special health care needs who have a source of payment for medical services continues to include: continued advocacy with the Medicaid program in urging eligibility for CSHCN for any and all of the Medicaid Title XIX and XXI programs that are available for children; continue referral of families of CSHCN to the Nebraska Medicaid Program (all Medicaid titles and coverage available); continued coverage of CSHCN specialty care payments through MHCP; continued supplementation of private health insurance benefits where appropriate; continued referral to private medical insurance; continued referral to the CHIP medical insurance program (Nebraska State Comprehensive Health Insurance Program, which provides a State supplement to the insurance premium for those who are not insurable through any other means); continued funding and support of Genetics/Neurobehavioral clinics through Munroe Meyer Institute at the University of Nebraska Medical Center; and continued funding of and provision of MHCP Specialty Clinics for CSHCN.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Advocate with the Medicaid program in urging eligibility for CSHCN for any and all of the Title XIX and XXI progrrams thar are available for children | | **X** | | |
| 2. Continue referral of CSHCN to Medicaid | | **X** | | |
| 3. Continue coverage of CSHCN specialty care payments through MHCP | **X** | | | |
| 4. Continue referrals to private insurance and NE State Comprehensive Health Insurance Program | | **X** | | |
| 5. Fund and support Genetics/Neurobehavioral clinics through Munroe Meyer Institute at the UNMC | **X** | | | |
| 6. Continue MHCP Specialty Clinics | **X** | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Examining the potential of adding screenings that are inline with our current programs to ensure quality follow-up care for newborns.

### c. Plan for the Coming Year

In the upcoing year, we will be doing additional newborn metabolic screening which will include CF and CAH. This will increase the need for communication between programs to find funding sources for this care.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 80 | | 80 |
| Annual Indicator | | | 79.8 | 79.8 | 79.8 |
| Numerator | | | 327 | 327 | 327 |
| Denominator | | | 410 | 410 | 410 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 80 | 80 | 80 | 80 | 80 |

**Notes - 2002**

Only 2002 data available.

**Notes - 2003**

2003 data unavailable. Used 2002.

**Notes - 2004**

Data is unavailable for 2004. Used 2002.

### a. Last Year's Accomplishments

The CSHCN program in relationship to this measure carried out a wide array of activities. The Program partially funds the Answers4Families web site, which includes comprehensive information for families of children with special needs; school nurses; foster, adoptive and biological families; agencies; and children's mental health. The web site hosts discussion listservs targeted at the various populations, as well as information and Internet listservs for other populations with special needs. The CSHCN computerized tracking system, CONNECT, was modified in several ways. These modifications included: development of billing screens for Services Coordinators in the areas of Aged & Disabled Waiver (which contains children's waiver), Early Development Network, and Respite; functions and roles for each level of user

needed to be created, tested and distributed throughout the state's service areas; authorization assignments were determined and authority assigned to users to ensure documentation was appropriately completed for children's services; training of Services Coordinators regarding new screens and billing processes was completed; and training manual was revised to reflect these changes. This system integrates the populations of these programs into one database with a common "Client" screen. The system includes a needs assessment screen which tracks service needs by Program, caseload, services area, county, date of birth and will do unduplicated counts/tracking by all CSHCN in the system. It also includes level of care documentation for the Home and Community Based Medicaid Waiver and provides a Services Coordination billing document for EDN and Waiver non-HHS Contractors.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue to support Answers4Families web site, which includes comprehensive information for families of CSHCN and others, including listservs | | X | | |
| 2. Maintain and update CONNECT tracking system, which includes a needs assessment screen and tracks services by program, caseload, service area, county, date of birth, etc., and documents level of care. Upgrade to include payment for MHCP specialty cli | | X | | |
| 3. Host the Nebraska Resource Referral System through Answers4Families. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Additions to the CONNECT system now included are being trained and implemented. Talk of additional screens and options are being discussed to be added to CONNECT.

c. Plan for the Coming Year

Answers4Families will host the Nebraska Resource Referral System (NRRS) which includes over 8,000 social services type resources including child care, respite coordinator information, medical/health and public health information, food pantries, etc. Addresses: http://www.answers4families.org and http://www.answers4families.org/nrrs/. CONNECT will be upgraded to included payment for MHCP specialty clinics. Manual revisions will be made and staff trained on changes.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 10 | | 10 |
| Annual Indicator | | | 5.1 | 5.1 | 5.1 |
| Numerator | | | 118 | 118 | 118 |
| Denominator | | | 2314 | 2314 | 2314 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 10 | 10 | 10 | 10 | 10 |

**Notes - 2002**
This indicator did not meet the NCHS standards for reliability.

Only 2002 data available.

**Notes - 2003**
2003 data unavailable. Used 2002.

**Notes - 2004**
Data is unavailable for 2004. Used 2002.

a. Last Year's Accomplishments

Nebraska received a System Change Grant, Early Periodic Screening and Diagnostic Treatment Portals to Adulthood. This Grant will establish protocols and procedures to transition children from pediatric services to adult medical services. The children targeted are CSHCN. Current CSHCN clinics, described in a later section, will be used to pilot adding the transition component.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Through System Change Grant, EPSDT Portals to Adulthood, establish protocols and procedures to transition CSHCN from pediatric services to adult medical services. | | **X** | | |
| 2. Incorporate transition concepts into curriculum for new physicians | | | | **X** |
| 3. Hold medical transition clinics starting fall of 05; rural clinics to be conducted via telehealth. | **X** | | | |
| 4. Hold monthly educational video conferencs for educators, services coordinators, and school nurses. | | | | **X** |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Currently Nebraska is developing the clinics to pilot transitioning, identifying resident physicians to particpate in the clinics and establishg curriculum regarding aspects of various disabilities that need attention as youth transtion to adulthood. This will enhance the capaicy of doctors available to be possible medical homes as youth transiton to adult medical services.

c. Plan for the Coming Year

The coming year we plan to establish transition clinics statewide for youth with diabilities. At the same time we will add a medical compoent to the transition plans CSHCN have through the school system, as well as add to the capacity of physicians knowledgeable and willing to care for people with disabilities as they age and become adults.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |
| Annual Indicator | 75 | 78.9 | 78.2 | 77.9 | 82.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 83.9 | 85.4 | 86.9 | 88.5 | 90 |

**Notes - 2002**

Annual performance objectives based on HP 2010 objectives.

Nebraska relies on CDC's National Immunization Survey (NIS) for it's data. The most current data available is July 01- June 02; therefore, 2002 data is unavailable at the time of

submission. Numerator and Denominator information unavailable.

**Notes - 2003**

Annual performance objective based in HP 2010 objectives.

Nebraska relies on CDC's National Immunization Survey (NIS) for it's data. Numerator and Denominator information unavailable.

**Notes - 2004**

Nebraska relies on NCHS National Immunization Survey (NIS) for current vaccination estimates. Num and Denom are not provided because they are unknown.

## a. Last Year's Accomplishments

The Nebraska Immunization Program is located within the Office of Family Health. Primarily funded through the National Immunization Program (NIP) at the CDC, this program administers the 317 and Vaccine for Children (VFC) funds, as well as a Perinatal Hepatitis B project. In FFY 2004, the program supported 85 counties with public clinics across the state, 85 counties with public VFC providers and 213 VFC private providers. The Program also administered, through a subgrant, an immunization registry that includes all public immunization clinics except those in Lancaster County. Nebraska participates in the Hallmark Card program (a card signed by the Governor and First Lady and sent to the parents of all newborns with an immunization message).

Three community-based projects received Title V funds to address various immunization-related activities.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Support public immunization clinics and private VFC providers across the state. | | | X | |
| 2. Maintain current immunization registry in public immunization clinics. | | | X | |
| 3. Continue participation in Hallmark Card program. | | X | | |
| 4. Continue study of feasibility of new immunization registry for both the public and private sector. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The Nebraska Immunization Program continues to support 85 counties with public immunization clinics and 218 private VFC providers. The immunization registry continues to be in place, with current efforts focused on keeping it stable and updated, and looking ahead to how to support/maintain the registry in the future. A modest allocation of Title V funds has been made this year to the Immunization Program, as partial support for the registry.

Influenza vaccine was routinely administered to infants and young children for the first time in 2004/2005.

Currently, three community-based projects funded through Title V have an immunization component.

### c. Plan for the Coming Year

There will be a continuation of efforts to address the future of the immunization registry. Normal immunization-related activities will also continue. New vaccines and new combination vaccines have been licensed and will be integrated into the Immunization Program and the immunization registry.

## Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 20 | 19.5 | 19 | 18.5 | 18 |
| Annual Indicator | 19.2 | 19.9 | 18.4 | 18.5 | 17.8 |
| Numerator | 754 | 760 | 701 | 696 | 670 |
| Denominator | 39291 | 38137 | 37999 | 37675 | 37702 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 17.5 | 17.5 | 17.5 | 17.5 | 17.5 |

**Notes - 2004**

Provisional data, birth file will be cleaned and complete in fall 2005.

### a. Last Year's Accomplishments

The Nebraska Reproductive Health Program receives a modest allocation of Title V funds, which it in turn subrants to ten local agencies across the state to provide health services to women of child-bearing age, including teens. Services and related activities are as follows: women and teens of child-bearing age encouraged to plan for and space their pregnancies; pregnant women and teens educated on the need for early and continued prenatal care and provide referrals as needed; teens educated about preventing second teen pregnancies; outreach activities completed to reach minority and underserved women and teens of child-bearing age; education given to women and teens to decrease behaviors that put them at risk for STDs and HIV/AIDS; culturally appropriate educational materials used; pregnant women and women and teens at risk encouraged to have HIV testing; new ways to reach teens were developed; teens were provided education to abstain from sexual activity or to delay sexual

activity; communities were given information about teen pregnancy; confidential reproductive health services, including pregnancy testing, STD testing and treatment, HIV testing and counseling and contraception as requested provided; a sexual health assessment for risk of STD/HIV was completed on all women and teens; women and teens were educated on the use of tobacco, alcohol, and other substances and to stop use or decrease use during pregnancy or when planning a pregnancy; and referrals made as needed to drug/alcohol abuse services.

The Perinatal, Child and Adolescent Health Unit is also partially supported with Title V/MCH Funds. In addition, this unit administers the Abstinence Education Section 510 funds. FFY 2004 accomplishments for the Abstinence Education Program include: selection and start-up of eight grantee sites (O'Neill, Pierce, Neligh, Columbus, Lincoln (2), Alliance, Lexington.) beginning October, 2003; WAIT training in Lincoln, - November, 2003; program promotion media purchase -- KOLN/KGIN TV -- Girls/Boys State Basketball games, March 2004; other program promotion and visual aids, including Program Newsletter -- Winter and Summer editions and STD -- Poster/PSA Campaign -- May, 2004; held a Grantee Symposium, June 2004; conducted training in Hastings at YRC, May 2004, Lexington, August 2004 and in Ralston Public Schools, September, 2004; and facilitated awareness events in selected sub grant sites, (Pierce, Osmond, Neligh, Elgin, Ewing, Columbus, Lexington), and in collaboration with Norfolk SPRANS recipient in Macy, September, 2004.

Three community based projects received Title V funds to support youth development and other teen-pregnancy prevention related activities. Two of these projects specifically target racial/ethnic minority youth with youth-development activities based on cultural traditions.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Provide comprehensive reproductive health services through the NE Reproductive Health Program, including outreach and community education for adolescents. | X | | X | |
| 2. Support community-based abstinence education efforts and conduct statewide awareness activities. | | | X | |
| 3. Develop a stakeholder network to bring greater focus on youth development. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Office of Family Health continues to administer both the Reproductive Health Program and the Abstinence Education Program. Both programs work with networks of stakeholders interested in and committed to reducing rates of adolescent pregnancy. Three community-based projects continue youth development projects with Title V support.

Through a contractual arrangement, the Abstinence Education Program is organizing and further developing its stakeholder network to bring greater focus on youth development.

### c. Plan for the Coming Year

No major changes are planned for state-level operations in FY 2006. The competitive subgranting process may yield new community-based efforts related to reducing rates of teen pregnancy.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 17 | 17 | 17 | 17 | 17 |
| Annual Indicator | NaN | NaN | NaN | NaN | 44.6 |
| Numerator | 0 | 0 | 0 | 0 | 10489 |
| Denominator | 0 | 0 | 0 | 0 | 23518 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 45.7 | 46.8 | 47.8 | 48.9 | 50 |

**Notes - 2002**

Nebraska currently does not have a system to measure this performance measure.

**Notes - 2003**

Nebraska does not currently have a system to measure this performance measure.

### a. Last Year's Accomplishments

During FFY 2004, a major effort was initiated. The Nebraska Dental Health Division, in collaboration with the Office of Family Health, CDC, and the University of Nebraska Medical Center Pediatric Dental Residency Program developed plans and protocols for an open mouth survey of 3rd grade school children and their dental needs.

The Dental Health Division also conducted Nebraska's first-ever state-wide Oral Health Forum . More than 225 participants were involved in the 2-day conference which included training on everything from sealant programs and hospital dental programs to how to open a publc health dental clinic. The training was geared toward the new Health District dentists who are sitting on the local boards of health providing oral health expertise.

The Dental Health Division also provided support for those at the local level as they began to conduct needs assessment and strategic planning relative to oral health. The web page was updated (www.hhs.sate.ne.us/dental) to include downloadable materials and sessions from the NE State Oral Health Forum.

Three community-based projects funded through Title V had an oral health component: 1 conducting oral health screenings (population-base services; 1 providing acute dental care (direct services); and 1 leading community collaborative planning efforts (infrastructure building).

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Analyze and disseminate data from open mouth survey of 3rd graders conducted in FY 2005. | | | | X |
| 2. Dental Health Division to develop Call to Actio Plan using open mouth survey data. | | | | X |
| 3. Dental Health Division continues educational/informational activities (web site, list serve, educational materials, etc.) | | | X | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The open mouth survey of Nebraska 3rd graders has been completed. The calibration training for screeners was held in October 2004. During the 2004/2005 school year, 2019 children were screened at 57 Nebraska schools. Data entry has been completed, and preliminary data indicates: 40% of children are caries free in their primary and permanent dentition; 17.5% have untreated decay; and 44.7% of children have dental sealants. Further analysis of the data is underway.

The Dental Health Division continues its infrastructure development activities, including maintenance of its web site and a dental health listserve.

The 3 community-based projects funded through Title V in 2004 continue to provide oral health services in 2005.

## c. Plan for the Coming Year

When fully analyzed, the Open Mouth Survey data will be used to develop a Call to Action Plan to address the oral health needs of Nebraska children. The survey data will also be published and distributed.

The Dental Health Division will continue to inform and educate the public about the dental

needs of Nebraska children and mobilize community partnerships to develop oral health systems of care. Work with the dental and public health communities will be ongoing, to assure capacity and competency.

Because oral health is no longer among Nebraska's ten MCH/CSHCN priority needs, the potential for community based oral health projects to be funded in 2006 --2008 is less likely than it had been over the previous funding cycle.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 5 | 5 | 5 | 4.4 | 4.4 |
| Annual Indicator | 4.9 | 5.5 | 4.7 | 6.6 | NaN |
| Numerator | 18 | 20 | 17 | 24 | 0 |
| Denominator | 369427 | 363968 | 364293 | 364714 | 0 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 4.4 | 4.4 | 4.4 | 4.4 | 4.4 |

**Notes - 2002**

Annual performance ojbective based on national 1998 baseline data, beginning in 2003.

Note: Rates based on small numbers may be unreliable.

**Notes - 2004**

Provisonal data is way off, casue of death field in death file is not complete or cleaned. Should have final data by September (best estimate)

a. Last Year's Accomplishments

The Office of Disease Prevention and Health Promotion, Safe Kids program, is responsible for carrying out injury prevention activities for children 14 and under. One of the programs is Safe Kids Buckle Up which focuses on child passenger safety. In 2004, a total of 58 child safety seat check events/fitting stations were conducted across the state. In that, over 9,000 seats were checked, 3,858 seats distributed at a cost of $207,456. A total of 3,164 hours were spent conducting events with $49,000 in trained personnel value and $7,530 in volunteer value. The support of events came from local contributions as well as Safe Kids General Motors grants and Preventive Health and Health Services Block Grant funds.

Nebraska Child Passenger Safety Instructors across the state conducted the National Highway

Traffic Safety Administration certification courses in Omaha, Grand Island, Lincoln and Columbus. Through the PHHS Block Grant, staff was present as instructors and carried out grant activities. These courses have been implemented since 1999 in Nebraska. These activities have contributed to more children being in car seats from 86% in 2003 to 88% in 2004. This is a significant increase from 1999 in which only 56% of children were restrained. Currently, there are over 400 Certified Child Passenger Safety Technicians across the state in which the Safe Kids program provides technical assistance and grant opportunities. Certification courses are sponsored by Safe Kids and Nebraska Office of Highway Safety through grants and staff time.

With support from the Office of Family Health (Healthy Child Care grant), a total of seven 4-hour child passenger safety trainings were conducted using the Nebraska childcare curriculum. Through this training, 64 childcare providers participated and $4,200 worth of seats distributed.

Held a child passenger safety technician update in Kearney, NE. A total of 150 technicians from across the state attended.

The child passenger safety law was updated to include the following: all children under the age of 18 are prohibited from riding in the back of pickup trucks or cargo areas as a primary law.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Promote child passenger safety through Kids Buckle Up activity of Safe Kids program | | | X | |
| 2. Conduct National Highway Traffic Safety Administration certificaton courses for safety seat checks. | | | | X |
| 3. Conducted child passenger safety trainings for child care providers, and distributed seats as part of the training. | | | X | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The Nebraska Office of Highway Safety is supporting statewide child safety seat checks through a $7,000 grant with HHS Safe Kids. They are also supporting 12 fitting stations and four child passenger safety certification classes. Currently, classes have been held in Bellevue and Hastings. The community of Lincoln and North Platte will be hosting courses this fall. At years end, about 80 more people from various agencies will be trained.

The statewide injury prevention plan has been used to launch a new falls-related injury prevention program for children 14 and under. From the data, a more specific report was created that just focused on falls. The data then lead to creating a grant opportunity for local Safe Kids coalitions and chapters. Currently, eight projects are underway.

## c. Plan for the Coming Year

The Nebraska Child Passenger Safety Board will convene its meetings in the fall to discuss the 2006 training schedule as well as other issues affecting child passenger safety.

Funds are being sought to focus on the transportation of children with special health care needs and the Spanish speaking population.

Safe Kids Nebraska will continue to utilize Safe Kids/Chevy grants to help communities conduct child safety seat check events as well as trainings.

## Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 75 | 75 | 75 | 75 |
| Annual Indicator | 72.8 | 71.6 | 75.8 | 75.8 | 73.9 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 75 | 75 | 75 | 75 | 75 |

**Notes - 2002**

Nebraska uses the Ross Laboratory Survey for this indicator. The most recent information is 2001. Numerator and denominator information is unavailable. Annual performance objectives based on HP Objectives.

**Notes - 2003**

Nebraska uses the Ross Laboratory Survey for this indicator. The most recent information is 2002. Numerator and denominator information is available. Annual performance objectives based on HP Objectives.

**Notes - 2004**

Nebraska uses the Ross Laboratory Survey for this indicator. The most recent information is 2003. Numerator and denominator is not available. Annual performance objectives based on HP Objectives.

## a. Last Year's Accomplishments

The WIC Program continued its active promotion and support of breastfeeding. The Program received funding from USDA designated for establishing a breastfeeding peer counseling

program using "Loving Support." Two staff attended the management training for this program in June 2004. Other WIC activities included a news release for August 2004 as breastfeeding month. Materials and information for promotion were sent out to local WIC agencies.

In addition, a statewide breastfeeding help line continued to be supported with Title V funds and an additional Title V funded project focused on community-level supports for breastfeeding mothers.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue WIC breastfeeding and promotion activities, including peer counseling initiative. | | | X | |
| 2. Finalize and implement goals and strategies developed through the Nebraska Breastfeeding Promotion and Support Initative | | | | X |
| 3. Establish and maintain a state-wide breastfeeding coalition/network. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The WIC Program continues to include breastfeeding initiation and duration as goal areas for the Program. State and local staff attended train-the-trainer workshops for peer counseling, and peer counseling programs are now being implemented in some Nebraska communities.

Then, the Office of Family Health launched an inter-program initiative in January 2005 to promote and support breastfeeding. A steering committee of over 25 individuals, representing public health, businesses, employers, and primary care providers was formed and has met 3 times. The committee members have established 5 goals and recommended 2-3 strategies for achieving each goal. The focus of the committee' recommendations has been on the role that health care providers, the media, businesses/work places, and public health should play in supporting women's decisions to breastfeed. Yet this year, 2 forums will be held to get broader input on the goals and strategies from additional stakeholders. The committee members have also recommended that an ongoing breastfeeding collaborative be formed, for purposes of sharing resources and developing future projects. Primary staff for this initiative are the program managers for the Perinatal, Child, and Adolescent Health Unit and the Nebraska WIC Program.

The statewide breastfeeding help line and community-based project continue to be supported with Title V funds.

## c. Plan for the Coming Year

The Breastfeeding Initiative Steering Committee's recommendations will be finalized based on input received at the two forums completed in FFY 05. A work plan will be developed to phase in implementation of the recommendations. A structure will be determined for maintaining an ongoing, statewide breastfeeding collaborative, and steps taken to implement.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 25 | 50 | 75 | 95 | 95 |
| Annual Indicator | 36.3 | 60.9 | 88.8 | 97.6 | 98.2 |
| Numerator | 9043.1 | 15272 | 22665 | 25275 | 25966 |
| Denominator | 24912 | 25090 | 25529 | 25900 | 26443 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 99 | 99 | 99 | 99 | 99 |

**Notes - 2002**

Annual performance objective based on Mebraska Newborn Hearing Statues which set the objective of 95% by 2003.

**Notes - 2003**

Annual performance objective based on Nebrask'a Newborn Statutes which set the objective of 95% by 2003.

a. Last Year's Accomplishments

Nebraska Revised Statute SS71-4742 established that newborn hearing screening would voluntarily become the standard of care and that 95% of newborns would be screened for hearing prior to hospital discharge.

During calendar year 2004, 100% of the 67 birthing facilities were conducting newborn hearing screening and all but two were conducting the screenings during birth admission. Hospitals reported screening the hearing of 98.2% of newborns during the birth admission. The average refer rate was 3.5%. Outpatient re-screenings and/or diagnostic evaluations were completed for 84.2% of those needing follow-up services. Follow-up services were initiated at an average of 30.6 days of age. There were 26 infants identified with a permanent childhood hearing loss, an incidence of 1 per thousand newborns, and the average age of identification was 98.4 days. Early Intervention services were provided for 63% of those identified with a permanent childhood hearing loss with services being initiated at an average of 157 days.

Program staff worked with providers to improve reporting and referrals for diagnosis and treatment. Staff of two Early Head Start programs were trained to conduct otoacoustic emissions hearing screening through the Hearing Head Start demonstration project with the National Center for Hearing Assessment and Management. Collaborative linkages were established with family support programs, early childhood education, related professional associations and research projects.

The activities were a mixture of infrastructure building (development of an integrated electronic data reporting system, refinement of procedures, revitalization of the Advisory Committee, and expansion of referral networks) and population-based (screening and tracking). The target population is newborns and infants.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Administer Newborn Hearing Screeing Program as per NE Rev Stat 71-4742, including reporting/tracking provisions. | | | X | |
| 2. Promote screening of older infants and toddlers through the Hearing Head Start project. | | | X | |
| 3. Review and revise screening, diagnostic, and referral protocols for newborn hearing screening. | | | X | |
| 4. Develop electronic data reporting and tracking system as an integrated module of the Vital Statistics Reporting Systeym, with full implementation in late 2005. | | | | X |
| 5. Through HRSA/MCHB Universal Newborn Hearing Screeing and Intervention grant, support implementaion of medical home and family-to-family support systems, in conjunction with electronic reporting/tracking system. | | | | X |
| 6. Through CDC EHDI cooperative agreement, expand electronic data system and integrate with related child data systems. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The electronic data reporting and tracking system is being developed as an integrated module of the State of Nebraska's new Vital Statistics Reporting System. Full implementation of the new system is anticipated by the end of 2005.

Increased funding through a HRSA/MCHB Universal Newborn Hearing Screening and Intervention grant will support implementation of electronic reporting and tracking systems, medical home and family-to-family support systems, and professional development for hearing health professionals. A new CDC EHDI Tracking, Surveillance, and Integration cooperative agreement will facilitate the expansion of the electronic data reporting and tracking systems and integration with related child data systems.

An additional three Early Head Start programs will be included in the Hearing Head Start project, bringing the anticipated total of infants and toddlers to be screened to annually to over 530.

Screening, diagnostic, and referral protocols will be reviewed and revised, as needed, by the Advisory Committee. The revisions will incorporate the first five year's experience of the Nebraska Newborn Hearing Screening program and advances in the fields of early hearing detection and intervention, early intervention, audiological evaluation and management, and related medical specialties, including genetics.

### c. Plan for the Coming Year

With the benchmark of 95% of newborns screened during birth admission having been met for the last two years, program activities in calendar year 2006 will continue to focus on implementing the ongoing mandates of Nebraska's Infant Hearing Act: maintaining the tracking system, collecting required data, applying for federal funds, and providing consumer education. The goals and objectives identified in the federal funding applications (HRSA/MCHB and CDC) will be implemented to further develop the screening, diagnostic and services systems; expand the reporting and tracking systems; integrate with other child data systems; and refine the quality assurance mechanisms.

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 7.5 | 7 | 6.5 | 6 | 5.5 |
| Annual Indicator | 7.0 | 7.7 | 8.1 | 11.6 | 12.4 |
| Numerator | 31000 | 35540 | 38000 | 17000 | 18000 |
| Denominator | 441000 | 464150 | 468569 | 146000 | 145000 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 12.2 | 12 | 11.8 | 11.6 | 11.4 |

**Notes - 2002**

2001 & 2002 data is for children 0-18 years old.

Source: Nebraska Medicaid.

**Notes - 2003**

2002 & 2003 data is children 0-18 year old.

**Notes - 2004**

2004 data is uninsured children 0-18 year old<200%FPL . Data is a Medicaid estimate.

I am reseting targets for 2% yearly improvment.

### a. Last Year's Accomplishments

The Office of Public Health received funding for the Nebraska State Planning Grant in October 2003 to address the problem of the uninsured in the state. The Governor appointed members to the Nebraska Health Insurance Policy coalition to provide guidance and oversight to the project. The program conducted a household survey to identify characteristics of the uninsured, the barriers to insurance, and the estimated number of under-insured. Employers were also surveyed because of their role in providing health insurance. Focus groups were also conducted to identify barriers to obtaining health insurance beyond cost, to better understand how decisions were made concerning the purchase of health insurance, and to identify participants' perceptions on a few strategies for expanding health insurance coverage in the state.

The Medically Handicapped Children's Program provides payment for limited specialty care for children who have no other source of funding. An increase of referrals due to the limitations placed on eligibility for Kids Connection (Nebraska's SCHIP) and Nebraska Medicaid coverage for children has resulted in a conservative approach in determining eligibility and planning in preparation for setting formal priorities regarding services that can provided. The State of Nebraska regulations regarding the provision of direct care services was re-written during the past fiscal year. Some re-ordering of services was included in the re-write and provisions are included which allow the Program to be operated within available budget limitations.

Voices for Children, through its Covering Kids and Families in Nebraska project, worked with a coalition to increase enrollment in Kids Connection.

Gap filling services for the uninsured are provided by six federally qualified health centers. In addition, Nebraska has five Indian health Services Facilities. Four community-based projects supported by Title V provide direct care.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Nebraska Health Coaltion to finalize strategies and present to Governor, addressing issues of uninsured and underinsured. | | | | X |
| 2. MHCP continues to provide/pay for limited specialty services for CSHCN within available resources. | X | | | |
| 3. Voices for Children Covering Kids Project continues work with collaborators on promoting enrollment in Medicaid and SCHIP | | | | X |
| 4. Gap filling services provided through 6 FQHCs and 5 Indian Health Services facilities. | X | | | |
| 5. Community-based project(s) delivering direct services to uninsured/underinsured MCH populations to be selected through competitigve process (Sept. 05). | X | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |

| 10. | | | | |
|---|---|---|---|---|

b. Current Activities

The governor-appointed Nebraska Health Insurance Coalition held a series of 6 town hall meetings across the state during May 2005. Several proposed strategies in a draft plan were on the table for discussion, including: creating a Safety Net Commission to develop a plan for expanding the number of community health centers; expanding the use of drug discount programs; exploring the option of creating a central pharmacy organization to take advantage of prescription drug discounts offered by manufacturers; improving outreach to enroll eligible children and adults in Medicaid and Kids Connection (NE's SCHIP); and providing reinsurance coverage to insurers that cover small businesses. In addition, the Coalition has proposed the development and implementation of initiatives to reduce the cost of Medicaid and Kids Connection programs and use these savings to expand the programs (e.g., increase income level from 185 to 200 percent of federal poverty level for Kids Connection). Two specific cost cutting approaches were described: a Disease Management Program for Medicaid patients and joining a multi-state purchasing pool to negotiate lower prescription drug costs for Medicaid clients.

The gap filling and Title V supported services described for FY 2004 continue to serve the uninsured and underinsured. Voices for Children continues its work to increase enrollment of eligible children in Kids Connection through its Covering Kids and Families project.

c. Plan for the Coming Year

The Nebraska Health Insurance Coalition's plan and report of recommendations will be finalized and presented to policy makers. Next steps will then be determined. Considering that Medicaid reform is a priority for the HHS Finance and Support agency, the recommendations will likely be considered in the context of the agency's reform efforts.

The Voices for Children Covering Kids Project's child-related goals for the upcoming year include: reduce the number of uninsured children who are eligible for Medicaid or SCHIP coverage but remain uninsured and build knowledge, experience and capacity to achieve an enduring national and regional commitment to sustain beyond the grant period the enrollment and retention of children and adults in Medicaid and SCHIP. Strategies include outreach, simplification of enrollment and re-enrollment processes; and coordinate existing health care coverage programs.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 95 | 95 | 95 | 95 | 95 |
| Annual Indicator | 97.6 | 95.4 | 97.0 | 96.7 | 96.5 |
| Numerator | 128828 | 148529 | 157118 | 160596 | 152470 |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | 132000 | 155679 | 162000 | 166000 | 158000 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 97.2 | 97.9 | 98.6 | 99.3 | 100 |

**Notes - 2002**

Source: Nebraska Medicaid

**Notes - 2003**

Source: Nebraska Medicaid

**Notes - 2004**

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a. Last Year's Accomplishments

Rural Nebraska continued to present real challenges regarding access to care for all populations, including MCH and CSHCN eligible for Medicaid. Medicaid managed care is only in place in 3 urban counties (Douglas, Sarpy, and Lancaster). The PHONE project, financed with Medicaid administrative funds (75%) and local match (25%), plays an important role in assuring access to Medicaid benefits for families living in rural Nebraska.

The Public Health Outreach Nursing and Education program (PHONE) is a contracted service with Nebraska HHSS. It provides community outreach and education to Medicaid and Kids Connection eligible families. Through PHONE, public health nurses are available statewide (90 rural counties) to assist health care providers with: missed or late appointments; failure to present Medicaid/Kids Connection cards at appointments; failure to comply or follow-up with recommended medical, dental or vision care; inappropriate use of the emergency room; transportation barriers; or lack of coverage. The PHONE nurses assist eligible or potentially eligible Medicaid/Kids Connection families by: helping to find medical, dental or vision homes, assisting with the application process; providing education on accessing appropriate levels of care; identifying barriers; and offering information on community resources and assisting with referrals.

The Medically Handicapped Children's Program continued its work in referring CSHCN to Medicaid, as appppropriate. It also continued its plans to begin a Telemedicine pilot project with the University of Nebraska Medical Center in Omaha, the Educational Services Unit and the Hospital in Scottsbluff. The Children with Special Health Care Needs Program, Special Education Division of the Nebraska Department of Education and Munroe Meyer Institute (a LEND grant recipient) of the University of Nebraska Medical Center entered into an agreement to begin the project. The Specialty Services Clinics contract between the University and the CSHCN Program includes the wording "…to determine protocols, rates and methodology to begin a series of pilot/demonstration telemedicine sessions that are efficient in time and costs to families and medical/paramedical staff." This pilot has been successful and will be an essential element in the transition clinics. Telemedicine has been an excellent alternative to provide specialized medical care to families isolated in remote rural areas. It adds needed support to local physicians attending families with children with special health care needs. It will also be utilized in collaboration with a Centers for Medicare & Medicaid Services federal grant to transition children with special health care needs to adult medical services due to the ongoing success of this work.

The referrals and presumptive eligibility determinations carried out by the Title V/MCH and

CSHCN providers and the PHONE nurses are enabling services and the target populations are infants, children, and CSHCN.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Community outreach and education provided to Medicaid and SCHIP eligilbe families through Medicaid-public health nurse program. | | X | | |
| 2. Ongoing referrals through MHCP to Medicaid. | | X | | |
| 3. MHCP, in collaboration with UNMC and the ESU and hospital in Scottsbluff, continue work on telemedicine pilot project. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Medicaid Program realigned its PHONE contracts and began looking at enhancements for the new contract period beginning July 1, 2005. Among the enhancements negotiated with the Office of Family Health is the addition of child care health consultation as a new responsibility for the PHONE nurses. This new activity will expand the venues in which the PHONE nurses can connect children and their families with a medical home and enrollment in Medicaid.

c. Plan for the Coming Year

Continue collaborations with Medicaid and the PHONE nurse contracts. Continue telemedicine project for CSHCN.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 1 | 1 | 1 | 0.9 | 0.9 |
| Annual Indicator | 1.3 | 1.3 | 1.3 | 1.2 | 1.2 |
| Numerator | 313 | 322 | 331 | 315 | 327 |
| Denominator | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | 24643 | 24818 | 25381 | 25900 | 26323 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 |

**Notes - 2002**

Annual performance objectives based on HP 2010 ojectives beginning in 2003, using "best fit lines".

**Notes - 2003**

Annual performance objectives based on HP 2010 objectives beginning in 2003, using "best fit lines".

## a. Last Year's Accomplishments

Baby Blossoms (formerly the Omaha Area Perinatal Collaborative) developed a blueprint for improving perinatal outcomes, based on an analysis of fetal and infant mortality using the Perinatal Periods of Risk model. Using this blueprint, work groups began developing strategies in a number of areas with the potential for impacting preterm and low birth weight rates. The Office of Family Health continued its collaboration with Baby Blossoms.

Title V-funded Perinatal, Child and Adolescent Health Unit carried out a number of projects with potential impact on this measure. It completed prenatal tobacco cessation activities with tobacco settlement funds, including the roll-out of the media/information campaign materials developed with these funds in FY 2003. Tobacco settlement funds were no longer available for Family Health efforts in FY 2004.

Thirteen prenatal care projects were funded. Projects include: Blue Valley Community Action (perinatal case management, prenatal education and tobacco cessation for pregnant women), Central Nebraska Community Services, Inc. (home visits for high-risk pregnant mothers and children), Lancaster County Health Department (tobacco cessation for pregnant women), Lincoln Medical Education Foundation, Inc. (screening, assessment, and intervention for pregnant women identified at risk for substance abuse), NAF Multicultural Human Development Corporation (direct care and outreach to Hispanic women and children), Omaha Tribe (direct health care for Native Americans), Panhandle Partnership for Health and Human Services (prenatal case management), Ponca Tribe (direct care), Sarpy/Cass Department of Health and Wellness (prenatal and postpartum smoking cessation), South Heartland District Health Department (develop resources on prenatal/perinatal and infant health), University of Nebraska Medical Center (direct care, prevention and education activities) and Winnebago Tribe of Nebraska (prenatal education).

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Support and collaborate with local projects, such as Omaha's Baby Blossoms. | | | | **X** |
| 2. Work with the Nebraska Medicaid program in perinatal care quality assurance efforts. | | | | **X** |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 3. Select community-based projects with LBW/preterm birth prvention strategies through competitive process (Sept. 05). | X | X | X | |
| 4. Convene stakeholders to develop comprehensive perinatal care strategies addressing LBW, preterm births, and infant mortality (fall 05). | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Activities and projects described for FY 2004 continued in FY 2005. In addition, the Office of Family Health expanded its working relationship with Nebraska Medicaid and its managed care contractor in reviewing prenatal care quality assurance data. Family Health staff contributed to the development of a prenatal care performance improvement project.

c. Plan for the Coming Year

The reduction of preterm birth and low birth weight rates is a newly identified priority. The Office of Family Health will work with stakeholders in developing new and enhancing existing strategies.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 10 | 9.5 | 9 | 8.5 | 8 |
| Annual Indicator | 11.1 | 13.0 | 9.8 | 9.9 | NaN |
| Numerator | 15 | 17 | 13 | 13 | 0 |
| Denominator | 134909 | 130881 | 132107 | 130871 | 0 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 7.5 | 7.5 | 7.5 | 7.5 | 7.5 |

**Notes - 2002**

Annual performance objective based on HP 2010 objectives beginning in 2003, using "best fit line."

Note: Rates based on small numbers may be unrealiable.

**Notes - 2003**

Annual performance objective based on HP 2010 objectives beginning in 2003, using "best fit line."

**Notes - 2004**

Provisonal data is way off, casue of death field in death file is not complete or cleaned. Should have final data by September (best estimate)

## a. Last Year's Accomplishments

The Child Death Review Team completed its review of 1996-2001 deaths. Its July 2004 report summarized data for the 6-year period, including triggering factors when known. The report also included these recommendations: all teenagers need access, including financial access, to confidential, professional mental health services; broad-based public education efforts are needed to draw attention to and awareness of teen suicide as a preventable cause of death for youth; parents who keep firearms in the home must understand importance of storing and locking firearms and ammunition separately and in inaccessible locations; and suicidal gesture, no matter how "harmless" it seems, demands immediate professional attention.

The Nebraska Suicide Prevention Task Force developed and made available a suicide prevention curriculum for educators, health care providers, and adult commuminty members. The Youth Residential Treatment Center's (YRTC) suicide prevention program received regional and national attention. Pilot screening projects for children at risk of suicide based on the "TeenScreen(r) Program" were being considered by the YRTC, the University of Nebraska Medical Center and BryanLGH Medical Center. Project Relate, a statewide mental health anti-stigma public service campaign, began in April 2004.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. NE Suicide Prevention Task Force developed and disseminated prevention curriculum for clergy, law enforcement, health care providers, and educators. | | | X | |
| 2. Develop further collaborative relationships with NE State Suicide Prevention Committee, and its three subcomittees. | | | | X |
| 3. | | | | |
| 4. | | | | |
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| 6. | | | | |
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| 10. | | | | |

## b. Current Activities

Nebraska's Suicide Prevention Task Force has developed suicide prevention curriculum for

Clergy, Law Enforcement, Health Care Providers, and Educators. A core module was also developed for the general public and is available in English and Spanish. The curricula continue to be disseminated and have been presented to a national audience and have been distributed to numerous other states.

The Nebraska Suicide Prevention Task Force has submitted an application for Garrett Lee Smith funds, available through SAMSHA. These funds are targeted at prevention of suicide in youth under age 24. The main goals of the application include: Strategic Planning, Family Support and Integration of Service Systems. No state funding is currently allocated to this Task Force so all work is being carried out by a volunteer committee.

### c. Plan for the Coming Year

The Nebraska State Suicide Prevention Committee has three subcommittees, Awareness, Intervention, and Methodology. The subcommittees have developed a 2005-2006 state plan. The Office of Family Health will further develop a working relationship with the Committee and identify opportunities to partner in carrying out the subcommittees' goals and planned activities.

## Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |
| Annual Indicator | 82.4 | 74.5 | 70.7 | 65.4 | 70.3 |
| Numerator | 258 | 240 | 234 | 206 | 230 |
| Denominator | 313 | 322 | 331 | 315 | 327 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 74.3 | 78.2 | 82.1 | 86.1 | 90 |

**Notes - 2002**

Levels of perinatal care are not formally established/ monitored except for Medicaid reimbursement purposes. Therefore, facilities for high-risk deliveries & neonates for this performance measure are based on Medicaid reimbursement information. In 2001, the number of levels 3 (testing) hospitals was reduced from 10 hospital to 4 hospitals. This reductions is reflected in the decreased in percentage of VLBW infants delivered at high risk facilites in 2001 & 2003.
In adition, this does not reflect Nebraska resident infants that may be born at a high risk

facilities outside of Nebraska (for example, at Children's Hospital in Denver, CO and Sacred Heart Hospital in Yankton, S.D.)

**Notes - 2003**

Levels of perinatal care are not formally established/monitored except for Medicaid reimbursement purposes. Therefore, facilities for high-risk deliveries & neotates for this performance measure are based on Medicaid reimbursement information. In 2001, the number of level 3 (testing) hospitals were reduced from 10 hospitals to 4 hospitals. These reductions are reflected in the decrease in percentage of VLBW infants delivered at high risk facilities beginning in 2001. In addition, this does not reflect Nebraska resident infants tha be be born at high risk facilities(for example, at Children's Hospital in Denver, CO and Sacred Heart Hospital inYankton, SD)

**Notes - 2004**

Levels of perinatal care are not formally established/monitored except for Medicaid reimbursement purposes. Therefore, facilities for high-risk deliveries & neotates for this performance measure are based on those reimburesed by Medicaid . In 2001, the number of level 3 (testing) hospitals were reduced from 10 hospitals to 4 hospitals. These reductions are reflected in the decrease in percentage of VLBW infants delivered at high risk facilities beginning in 2001. In addition, this does not reflect Nebraska resident infants tha be be born at high risk facilities(for example, at Children's Hospital in Denver, CO and Sacred Heart Hospital inYankton, SD)

I reset targets to hit 90% in five years

## a. Last Year's Accomplishments

Nebraska does not have a formal system of perinatal regionalization. Nebraska Title V/MCH has not focused on issues related to maternal transport in recent years. These facts reflect the policy environment, including the absence of statutory provisions related to perinatal regionalization.

Local efforts assessed circumstances surrounding perinatal systems and care provided to VLBW infants. Baby Blossoms, formerly the Omaha Area Perinatal Collaborative, examined these issues. Baby Blossoms includes the University of Nebraska Medical Center and the Douglas County Health Department, both funded in part through the Title V/MCH Block Grant. In addition, the Office of Family Health continued its work with the collaborative. Baby Blossoms developed a blue print for action, and worked on issues including care issues for VLBW infants.

The Office of Family Health worked with the Nebraska Medicaid Program and ShareAdvantage, its managed care contractor, in reviewing prenatal care quality assurance data and developing a prenatal care performance improvement project.

The Nebraska Medical Association continued its work under contract to review neonatal deaths, providing information to the Chief Medical Officer regarding their findings.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Omaha Baby Blossoms assessed issues related to care for VLBW infants and included related strategies in its blue print for reducing infant mortality. | | | | X |

| | | | | |
|---|---|---|---|---|
| 2. Continue contract with the Nebraska Medical Association to review neonatal deaths. | | | | X |
| 3. Continue work with Nebraska Medicaid Program in the area of perinatal quality of care provided through Medicaid Managed Care. | | | | X |
| 4. Convene stakeholders to develop comprehensive perinatal care strategies addressing LBW, preterm births, and infant mortality (fall 05). | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Activities described for FY 2004 continue.

c. Plan for the Coming Year

With the recent identification of new priority needs, the Office of Family Health will be carrying out strategic planning to address these needs. The issue of quality/content of perinatal care, including maternal transport, will be among the issues addressed.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |
| Annual Indicator | 82.9 | 82.8 | 83.1 | 83.3 | 82.7 |
| Numerator | 20429 | 20558 | 21094 | 21574 | 21773 |
| Denominator | 24643 | 24818 | 25381 | 25900 | 26323 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 84.6 | 85.6 | 87 | 88.5 | 90 |

**Notes - 2002**

Annual performance ojbectives based on HP 2010 objectives.

**Notes - 2003**

Annual performance objectives based on HP 2010 objectives.

**Notes - 2004**

Reset targets to meet HP2010 of 90% in 5 years

## a. Last Year's Accomplishments

Thirteen prenatal care projects were funded. Projects include: Blue Valley Community Action (perinatal case management, prenatal education and tobacco cessation for pregnant women), Central Nebraska Community Services, Inc. (home visits for high-risk pregnant mothers and children), Lancaster County Health Department (tobacco cessation for pregnant women), Lincoln Medical Education Foundation, Inc. (screening, assessment, and intervention for pregnant women identified at risk for substance abuse), NAF Multicultural Human Development Corporation (direct care and outreach to Hispanic women and children), Omaha Tribe (direct health care for Native Americans), Panhandle Partnership for Health and Human Services (prenatal case management), Ponca Tribe (direct care), Sarpy/Cass Department of Health and Wellness (prenatal and postpartum smoking cessation), South Heartland District Health Department (develop resources on prenatal/perinatal and infant health), University of Nebraska Medical Center (direct care, prevention and education activities) and Winnebago Tribe of Nebraska (prenatal education).

The Office of Family Health worked with Nebraska Medicaid and its managed care contractor in reviewing prenatal care quality assurance data. Family Health staff contributed to the development of a prenatal care performance improvement project, which included early entry into prenatal care as a performance measure.

Baby Blossoms project examined prenatal care issues through focus groups with women in the Omaha area, and used the information in developing its blue print for action.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Omaha Baby Blossoms assessed issues related to access to prenatal care and included related strategies in its blue print for reducing infant mortality | | | | X |
| 2. Continue work with Nebraska Medicaid Program in the area of perinatal quality of care provided through Medicaid Managed Care. | | | | X |
| 3. Community based projects with direct and enabling services related to prenatal care to be selected through competive process (Sept. 05). | X | X | | |
| 4. Maintain Healthy Mothers, Healthy Babies helpline, to assist women in locating prenatal care and related resources. | | | X | |
| 5. Nebraska Health Insurance Coaltion developing strategies with potential of increasing financial access to prenatal care. | | | | X |
| 6. Convene stakeholders to develop comprehensive perinatal care strategies addressing LBW, preterm births, and infant mortality (fall 05). | | | | X |
| 7. | | | | |
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| 10. | | | | |

b. Current Activities

Projects and activities described for FY 2004 continue. Use of the Healthy Mothers, Healthy Babies helpline is under review, to determine how to better use this tool to increase access to prenatal care and other services.

The work of the Nebraska Health Insurance Coalition yielded draft strategies with the potential of increasing financial access to prentatal care.

c. Plan for the Coming Year

As part of its strategic planning process to address the newly identified priority needs, the Office of Family Health will consider how it can more practically promote early prenatal care, considering the wide range of barriers that includes: lack of insurance, provider shortages, language access, cultural competency, location and hours of clinical services, and related issues.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 3: *Incidence of confirmed SIDS cases (per 1,000 live births) among African American and Native American infants*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 3.0 | 2.9 | 2.8 | 2.5 | 2.2 |
| Annual Indicator | 2.9 | 2.8 | 3.1 | 2.8 | 3.1 |
| Numerator | 24 | 24 | 27 | 25 | 29 |
| Denominator | 8314 | 8581 | 8808 | 9073 | 9325 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 2.5 | 1.9 | 1.4 | 0.8 | 0.3 |

**Notes - 2002**

Rates are based on 5 year averages. Annual performance objectives based on HP 2010 Objectives beginning in 2003, using "best fit lines".

Note: Rates based on small numbers may be unreliable.

**Notes - 2004**

Because numbers are so small this is (and has been) a 5 year average

## a. Last Year's Accomplishments

This state performance measure was chosen to address a priority need identified in 2000: "reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities" and "eliminate racial and ethnic health disparities." While the incidence of SIDS in Nebraska has decreased by over 50% since the inception of the "Back to Sleep" campaign in 1994, the rate of SIDS death among African American and Native American infants has been as much as three times higher than that for whites.

2004 was a transition year for Nebraska's efforts. The SIDS risk reduction tee shirt campaign continued, with a supply of tee shirts provided to birthing hospitals early in FFY 2004. Current research on safe-sleep practices was reviewed and preliminary plans were made for a Safe Sleep Initiative. One community project continued to be funded to provide population-based SIDS/infant mortality prevention to Native Americans. Collaborative efforts were maintained with the Omaha Baby Blossoms group, including its SIDS work group.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Through Safe Sleep Initiative, develop and disseminate comprehensive, consistent safe sleep message for parents, providers, and general public. | | | X | |
| 2. Through Safe Sleep Initiative, develop and implement system strategies related to SIDS and safe sleep, including death scene investigations, cause of death coding, hospital and child care practices, and child care regulations. | | | | X |
| 3. | | | | |
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## b. Current Activities

A Nebraska Safe Sleep Initiative was launched, with the first meeting of the Steering Committee held in April 2005 and a second meeting held in June 2005. The committee members have considered current research on risks associated with SIDS and other sleep-associated deaths, developed an outline of a "Safe Sleep" message, and identified system-level issues to be addressed to better promote safe-sleep. Office of Family Health staff are now working with the Omaha Baby Blossoms work group to refine the safe-sleep message.

In preparation for the work of the committee, a post-card survey of moms giving birth in 2004 was conducted to augment information gathered through PRAMS regarding sleep-position, including feedback on the tee shirt campaign. In addition, a survey of birthing hospitals gathered data on hospital safe-sleep protocols and educational efforts.

The community project funded in 2004 continued SIDS risk reduction activities in 2005

### c. Plan for the Coming Year

This state performance measure is being retained for the upcoming period. The work of the Nebraska Safe Sleep Initiative Committee will continue. In coordination with the Omaha Baby Blossoms work group, a consistent "Safe Sleep" message will be launched, including use of media outlets. A report with recommendations for system-level changes will be prepared and finalized. Upon approval of the report, recommended strategies will be implemented.

## State Performance Measure 4: *Percent of women of child-bearing age who report smoking in the last 30 days*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 21% | 21 | 21 | 22 | 19 |
| Annual Indicator | 27.3 | 24.8 | 24.4 | 25.2 | 21.1 |
| Numerator | 84464 | 80978 | 78209 | 79968 | 68369 |
| Denominator | 309600 | 326578 | 320326 | 317204 | 324598 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 19.3 | 17.5 | 15.6 | 13.8 | 12 |

**Notes - 2002**

2002 data unavailable.

Annual performance objectives based o HP 2010 objectives beginning in 2003, using "best fit lines."

**Notes - 2003**

"Women of child-bearing age" are women between the ages of 18-44.

Source: Nebraska BFRSS

**Notes - 2004**

Weighted data so num and denom are estimates. - BRFSS. I have re set the targets to reach HP2010 of 12% in 5 years.

### a. Last Year's Accomplishments

This performance measure was previously chosen as a way to track progress in addressing formerly identified Priority Need #6 -- reduce use of tobacco, alcohol, and illicit substance among youth and women of childbearing age.

The perinatal tobacco materials developed with tobacco settlement materials were produced

and distributed. Boxes of promotional materials (patient brochures, posters, chart stickers, health care provider lapel buttons, pocket guides, etc.) were distributed to primary care providers as a direct mailing, and made available to others upon request. The tobacco cessation quit-line was promoted, until its discontinuance in May 2004 when funds were no longer available to support the line. Four community-based projects funded through Title V had a tobacco cessation component. Four additional community projects, with the support of tobacco settlement funds, continue in this fiscal year.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maintain and distribute perinatal tobacco materials to health care providers; promote quit line. | | | X | |
| 2. Collaborate with Tobacco Free Nebraska in developing a tobacco cessation strategic plan; implement applicable strategies related to MCH populations. | | | | X |
| 3. | | | | |
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## b. Current Activities

The perinatal tobacco materials are being maintained and sent to health care providers upon request. The national quit line is now being used and promoted, until a new state quit line is developed using CDC funds. The Office of Family Health is working with Tobacco Free Nebraska in the development of a tobacco cessation strategic plan The four Title V funded community projects continue, but tobacco settlement funds are no longer available to support the other four projects.

## c. Plan for the Coming Year

This measure is being retained for the upcoming period. Collaborative work with Tobacco Free Nebraska will continue. The most recent legislative session resulted in a restoration of some of the tobacco settlement funds previously lost by that program. With Tobacco Free Nebraska's emphasis on building capacity around cessation (versus prevention and environmental tobacco smoke), the Office of Family Health will concurrently find ways to better promote cessation activities for women of reproductive age and youth.

Reduction of tobacco use for women and youth had strong support as one of the 10 priority needs identified through the recently completed needs assessment. It is thus anticipated that community-based proposals addressing tobacco will be submitted through the competitive process currently underway.

State Performance Measure 5: *Incidence of neural tube defects (per 10,000 live births)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 3.5 | 3.5 | 3.5 | 6.9 | 6.4 |
| Annual Indicator | 7.7 | 8.5 | 7.5 | 7.3 | 4.6 |
| Numerator | 19 | 21 | 19 | 19 | 12 |
| Denominator | 24643 | 24818 | 25381 | 25900 | 26291 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 5.8 | 5.3 | 4.7 | 4.5 | 4.3 |

**Notes - 2002**

Rates based on small numbers may be unreliable. Annual performance objective based on HP 2010 Objectives beginning in 2003, using "best fit line."

**Notes - 2003**

Rates based on small numbers may be unreliable. Annual performance objective based on HP 2010 Objectives beginning in 2003, "best fit line."

## a. Last Year's Accomplishments

This measure relates to the previously identified Priority Need #5 -- reduce infant mortality with an emphasis on racial/ethnic disparities. Neural tube defects are among the most common birth defects contributing to infant mortality and morbidity, and one-half to two-thirds can be prevented through the daily use of folic acid among women of childbearing age.

The Office of Women's Health, through a March of Dimes grant, continued activities initiated in a previous year. Through a contractual arrangement, the Office of Women's Health completed focus groups with women of child bearing age to assess knowledge of and barriers to using folic acid. This information was used to develop folic acid materials that were provided to all family planning clinics and distributed at events such as the Women's Health Symposium.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Office of Women's Health maintains/distributes folic acid materials and includes folic acid information on its website. | | | **X** | |
| 2. Incorporate neural tube defects and prevention of other birth defects in comprehensive planning for LBW, preterm births, and infant mortaltiy. | | | | **X** |
| | | | | |

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b. Current Activities

The Office of Women's Health continues to maintain folic acid materials and its website includes folic acid information. The Office is working on a folic acid bookmark as part of a series being developed with the University of Nebraska Medical Center and the Olson Center for Women's Health.

c. Plan for the Coming Year

This measure is being discontinued. The Office of Women's Health will continue to be the contact point for folic acid information, and the Office of Family Health will utilize this resource.

Preliminary work is being done to develop preconception/interconception strategies to improve perinatal outcomes. Folic acid will be incorporated into these broader strategies.

State Performance Measure 6: *Hospitalizations for injuries (per 100,000), birth to 14 (intentional and unintentional)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 140 | 140 | 130 | 200 | 120 |
| Annual Indicator | 358.4 | 367.3 | 315.7 | 325.5 | NaN |
| Numerator | 1324 | 1337 | 1150 | 1184 | 0 |
| Denominator | 369437 | 363968 | 364293 | 363707 | 0 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 325.4 | 324.8 | 324.2 | 323.5 | 322.9 |

**Notes - 2002**

2002 data unavailable.

**Notes - 2003**

2003 data unavailable.

**Notes - 2004**

Hospital Discharge Data not available until October 2005.
I reset targets to represent a 2% yearly improvment.

## a. Last Year's Accomplishments

This measure was chosen as a means for assessing progress in addressing previously identified Priority Need #7 -- reduce rates of injury, both intentional and unintentional, among MCH/CSHCN populations.

As previously described, the Office of Disease Prevention and Health Promotion provides leadership for the agency in the area of injury prevention. See NMP #10 and #16 for related activities. In addition, a collaboration between the Nebraska SAFE KIDS Program and the Office of Family Health's SSDI Project resulted in the preparation of "The Report on Unintentional Fall Related Injuries, 2001 Data." This report identified falls as the leading cause of injury-related hospitalizations for Nebraska children and provides insight into risk factors associated with this major cause of injury.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Collaborate with Nebraska Safe Kids in promoting child passenger safety. | | | X | |
| 2. Develop and implement strategies regarding infant suffocation as part of Safe Sleep initiative. | | | X | |
| 3. Collaborate with Protection and Safety in developing a state plan for the prevention of child abuse and neglect; implement applicable primary prevention strategies. | | | X | X |
| 4. | | | | |
| 5. | | | | |
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| 10. | | | | |

## b. Current Activities

See NPM #10 and #16 for related information. A new focus for injury prevention this year has been the Safe Sleep initiative, which is closely examining sleep-associated infant deaths attributable to suffocation. A special assignment to the Child Death Review Team was an examination of several "SIDS" deaths reported in the first quarter of calendar year 2005. This work has yielded a better understanding of risks associated with bed-sharing and/or unsafe sleep surfaces/environments.

## c. Plan for the Coming Year

Two separate state performance measures have been chosen for the upcoming period, to better monitor intentional versus unintentional injury. Collaborations will continue with Nebraska SAFE KIDS, including joint planning on prevention of falls as a major cause of childhood injury. Strategies recommended by the Safe Sleep Initiative Steering Committee will be implemented. A new focus for the coming year will be the development of primary prevention strategies to reduce injuries due to abuse/neglect. In this regard, the Office of Family Health will be working with Protection and Safety staff in the development of a child abuse/neglect prevention plan.

State Performance Measure 7: *Percent of teens who report use of alcohol in last 30 days*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 52% | 45 | 47 | 52 | 58 |
| Annual Indicator | NA | 47.0 | 47.0 | 46.5 | 46.5 |
| Numerator | | 846 | 846 | 60855 | 60855 |
| Denominator | | 1800 | 1800 | 130871 | 130871 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 45.6 | 44.6 | 43.4 | 42.9 | 42 |

**Notes - 2002**

State performance measure wording was changed in 2001 to reflect the HP 2010 objective. As a result, comparison to data presented prior to 2001 due are not available.

Annual performance objective based on HP 2010 Objectives beginning in 2001, using "best fit lines".

**Notes - 2003**

State performance measure wording was changed in 2001 to reflect the HP 2010 objective. As a result, comparison to data presented prior to 2001 are not available.

Nebraska's YBRS is administered every other year. Currently YRBS does not include NE's largest school district, Omaha Public Schools. This creats invalidity for statewide analysis.

Weighted data set - therefore,num and dem are estimates.

**Notes - 2004**

Nebraska's YBRS is administered every other year, therefore data is from 2003. Currently YRBS does not include NE's largest school district, Omaha Public Schools. This creats invalidity for statewide analysis.

I reset target to reflect a 2% yearly improvement

## a. Last Year's Accomplishments

This measure was chosen to gauge progress in addressing previously identified Priority Need #6 -- reduce use of tobacco, alcohol, and illicit drugs among youth and women of child-bearing age.

Office of Family Health staff continued their participation in the State Incentive Cooperative Agreement (SICA) project, a state/federal partnership to reduce substance abuse among youth ages 12 to 17. A SICA-sponsored Nebraska Risk and Protective Factor Student survey was implemented with Nebraska schools and communities, identifying baseline data on risk and protective factors within communities across the state. Fourteen community coalitions were awarded $2.7 million in first-ear SICA funding to implement culturally and locally appropriate substance abuse prevention policies, practices, and programs directed towards youth.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Participate in State Incentive Cooperative Agreement project to reduce substance abuse among youth, including State Substance Abuse Epi workgroup. | | | | X |
| 2. Identify new partners and develop collaborative strategies as part of Adolescent Health Program | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The SICA sponsored survey data collected in the previous year was utilized as part of the Title V comprehensive needs assessment, with SICA project staff participating in the youth work group. This engagement in the SICA project has thus further built MCH capacity in the area of youth substance abuse.

In addition, staff with the Office of Family Health's MCH Epidemiology Unit participated in a newly formed State Substance Abuse Epi workgroup. Lead by NHHS Behavioral Health staff, this work group will further develop our assets in this area.

## c. Plan for the Coming Year

This performance measure is being maintained for the upcoming period. An emphasis will now be placed on moving from assessment to the development of collaborative strategies specifically related to youth alcohol use. New partners will be identified and engaged in the planning process to be lead by Nebraska's Adolescent Health Coordinator.

State Performance Measure 9: *Percent of Medicaid-participating dentists who see an average of 25 or more Medicaid patients per month*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 17.0% | 17 | 18 | 18 | 19 |
| Annual Indicator | NA | 33.3 | NaN | NaN | NaN |
| Numerator | | 238 | 0 | 0 | 0 |
| Denominator | | 715 | 0 | 0 | 0 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 19 | 19 | 19 | 19 | 19 |

**Notes - 2002**

2002 data unavailable at time of submission.

**Notes - 2003**

2003 data unavailable at time of submission.

**Notes - 2004**

2004 data unavailable at time of submission.

a. Last Year's Accomplishments

Because Nebraska had limited capacity to collect data for NPM #9, this state performance measure was chosen as an alternative for tracking progress in assessing Priority Need #3 -- increase access to quality oral health care for MCH/CSHCN populations.

See NPM #9 for related activities.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Dental Health Division develops Call to Action Plan based on 3rd grader open mouth survey conducted in 2005. | | | | **X** |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

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|---|---|---|---|---|
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

See NMP #9 for related activities, particularly the Open Mouth Survey of Nebraska 3rd graders. This survey will now permit Nebraska to report on NPM #9.

c. Plan for the Coming Year

This state performance measure will be dropped for the upcoming period. The Dental Health Division will take the lead in developing a call-to-action plan, using the results of the Open Mouth Survey as baseline data. See NPM#9 for more details.

State Performance Measure 10: *Percent of CSHCN seen at CSHCN multidisciplinary team clinics who receive recommended nutritional follow-up services*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 75% | 75 | 75 | 90 | 90 |
| Annual Indicator | 93.3 | 100.0 | 95.7 | 72.7 | 23.9 |
| Numerator | 14 | 15 | 22 | 16 | 92 |
| Denominator | 15 | 15 | 23 | 22 | 385 |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |

**Notes - 2002**

Reporting has improved due to training of the Clinic's Lead Worker & availability of an easy printable reporting form in the Connect database system.

**Notes - 2003**

Reporting has improved due to training of the Clinic's Lead Worker and availability of an easy printable reporting form in the Connect database system.

**Notes - 2004**

Data decrepency (thought) due to new data wharehousing system; NE CONNECT.

a. Last Year's Accomplishments

Nutrition for children with special health care needs is an ongoing priority of MHCP. This priority is addressed by a nutritional consultant (Licensed Nutritional Medical Therap9s, LMNT) on all Specialty Services for Children and Youth multidisciplinary teams with input regarding the number who receive/have received nutritional counseling, those referred for nutritional counseling and numbers who receive nutritional counseling.

Every effort has been made to assure the LMNT is trained and experienced in working with children with special health care needs through review of their resume of training and experience before contracting for Team membership.

The MHCP and Waiver Services Programs encourage LMNT home visits by allowing special rates. Policy for MHCP includes in-home LMNT assessments and follow-up consultation for those families and children who are not seen by an MHCP multidisciplinary Team upon request of the family or the MHCP Services coordinator.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Nutritional consultants (Licensed Nutritional Medical Therapy) provide services to CSHCN through MHCP clinics and home visits. | X | X | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
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| 10. | | | | |

b. Current Activities

Continued activities as above and system and policy changes as needed to meet he purposes of this priority.

c. Plan for the Coming Year

This performance measure is being discontinued. The MHCP will continue LMNT services.

State Performance Measure 11: *Rates of hospitalization for asthma among children ages 5 - 14.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|

| Data | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 8.0 | 8 | 8 | 7.9 | 7.9 |
| Annual Indicator | 9.4 | 6.7 | 7.1 | 7.1 | NaN |
| Numerator | 238 | 165 | 175 | 175 | 0 |
| Denominator | 252389 | 247398 | 247235 | 247235 | 0 |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 7.8 | 7.8 | 7.7 | | |

**Notes - 2002**

2002 data unavailable at time of submission.

Annual performance objective based on HP 2010 Objectives beginning in 2003, using "best fit lines" (based on 24-26, children & adults aged 5 to 64 years)

**Notes - 2003**

2003 data unavailable at time of submission.

Annual performance objective based on HP 2010 Obectives beginning in 2003, using "best fit lines" (based on 24-26, children & adults aged 5 to 64 years)

**Notes - 2004**

Hospital Discharge Data not availabe until October 2005,

## a. Last Year's Accomplishments

This performance measure was chosen as a means to monitor progress in addressing previously identified Priority Need #1 -- childhood morbidity and mortality due to asthma needs to be reduced.

The Office of Disease Prevention and Health Promotion continued to administer a CDC asthma grant. The Office of Family Health's School and Child Health Nurse Coordinator continued to coordinate efforts with this project, linking them to school nursing and Healthy Child Care Nebraska. Three community-based projects received Title V Funds for asthma related activities.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Collaborate with Office of Disease Prevention/Health Promotion staff in linking asthma-related activities with school nursing and child care health consultants. | | | **X** | |
| 2. | | | | |
| 3. | | | | |

| | | | | |
|---|---|---|---|---|
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
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| 10. | | | | |

b. Current Activities

The CDC asthma grant ended September 30, 2004. As a consequence, asthma related activities conducted by the Office of Disease Prevention and Health Promotion were less intense. Spring of 2005, a new application was submitted to the CDC to again receive asthma related funding, and a notice of approval/disapproval is pending. Title V funded projects continued.

c. Plan for the Coming Year

This performance measure will not be continued in the upcoming period. Should the Office of Disease Prevention and Health Promotion again receive asthma grant funds, the Office of Family Health will continue its collaboration in implementing strategies, particularly in school settings.

State Performance Measure 12: *The rates of minority adolescent births.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 45 | 19.5 | 19 | 18.5 | 18 |
| Annual Indicator | 63.2 | 82.8 | 91.4 | 109.3 | 77.4 |
| Numerator | 852 | 917 | 1039 | 1271 | 916 |
| Denominator | 13480 | 11069 | 11368 | 11627 | 11840 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 76.5 | 76.2 | 76 | 75.9 | 75.6 |

**Notes - 2002**

**Notes - 2003**

Annual Performance Objective is based on Nebraska's 2010 Objective for adolescent

pregnancies, modified, because pregancy rates cannot be calculated by race/ethnicity because abortion data does not include race/ethnicity.

## a. Last Year's Accomplishments

This performance measure was chosen as a means to monitor progress in addressing both previously identified Priority Need # 4 -- decrease rates of adolescent, non-marital, and unintended pregnancies and Priority Need #10 -- eliminate racial and ethnic health disparities.

Two community-based projects receiving Title V funds specifically addressed teen pregnancy prevention and/or reduction of other related behavioral risks among racial/ethnic minority adolescents. The Nebraska Abstinence Education Program continued to enhance its outreach to racial/ethnic minority youth. Two of the eight communities funded through the program serve large Hispanic populations. Additional funds were also awarded on a one-time basis to the Winnebago Tribal area for the purpose of initiating abstinence education among tribal youth. The Nebraska Reproductive Health Program, funded through Title X and Title V, continued its targeting of racial/ethnic minority populations through special projects sponsored by community based organizations serving primarily racial/ethnic minority women and adolescents.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Outreach to and services provided to racial/ethnic minority adolescents through the NE Reproductive Health Program. | X | X | X | |
| 2. Outreach to and education provided to racial/ethnic minority adoelscents through the Abstinence Education Program. | | | X | |
| 3. Teen pregnancy prevention to be incorporated into comprehensive planning to address LBW, preterm births, and infant mortality. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Both the Abstinence Education and Reproductive Health Program continue their efforts to enhance services for racial/ethnic minority women and adolescents. The Abstinence Education Program is planning a major outreach event this fall, focusing on Hispanic youth.

## c. Plan for the Coming Year

This performance measure is not being continued. The Abstinence Education and Reproductive Health Program will maintain their efforts to reach and serve racial/ethnic minority adolescents.

An initiative focused on preconception health is being contemplated, and should approvals and resources be acquired, teen pregnancy prevention will be incorporated into larger system

strategies.

State Performance Measure 14: *The percent of African American women beginning prenatal care during the first trimester.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |
| Annual Indicator | 67.8 | 67.6 | 69.5 | 72.1 | 72.2 |
| Numerator | 932 | 928 | 998 | 1044 | 1114 |
| Denominator | 1374 | 1373 | 1435 | 1447 | 1543 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 79.5 | 82.1 | 84.7 | 87.3 | 90 |

**Notes - 2004**

I have reset targets to reach HP2010 of 90% in 5 years.

a. Last Year's Accomplishments

This state performance measure was selected to provide additional information on progress being made in addressing previously identified Priority Need #5 -- reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities.

Under NPM #15, community-based projects related to prenatal care are described. Of these, two have African American women as a significant portion of their target population. In addition, Omaha Healthy Start continued to address the need to improve access to prenatal care for African American women in north/northeast Omaha. The Office of Family Health continued its collaboration with both Omaha Healthy Start and with Omaha Baby Blossoms.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Work with Omaha Baby Blossoms in implementing FIMR, to gather additional information on barriers to care for that subset of African American mothers who lost an infant. | | | | **X** |
| 2. Develop comprehensive strategies for addressing LBW, preterm births, and infant mortality that address prenatal care for African Americans, including new immigrants. | | | | **X** |

| | | | | |
|---|---|---|---|---|
| 3. | | | | |
| 4. | | | | |
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| 10. | | | | |

b. Current Activities

In addition to activities described for last year, the Omaha Baby Blossoms collaborative has been actively pursuing the implementation of a FIMR project in the Omaha area. The Office of Family Health's MCH Epidemiology Unit has been assisting with planning activities for this project. FIMR may provide additional insight into barriers in accessing services, including prenatal care, for that subset of African American women who have lost an infant.

c. Plan for the Coming Year

This performance measure is being retained for the upcoming period. Strategies to increase access to early prenatal care will be re-evaluated in the light of Medicaid reform efforts. In addition, outreach and referral activities to new immigrants will be assessed in greater depth, to be certain language and cultural barriers are reduced.

## E. OTHER PROGRAM ACTIVITIES

The Perinatal, Child and Adolescent Health (PCAH) Program, within the Office of Family Health, continues to contract with Nebraska Methodist Hospital to provide the Healthy Mothers/Healthy Babies Helpline, Nebraska's toll-free telephone line, as required by statute. The PCAH Program Manager is the state-level contact person for the helpline. The HMHB Helpline provides 24-hour nurse-operator service to the MCH population statewide regarding health care questions, and information and referral for the following: Title V and Title XIX providers, Kids Connection, newborn screening disorder-specific information, and folic acid supplementation. Monthly call report data are tracked and analyzed in order to guide publicity efforts. When the line first began in 1992, calls averaged 7 per month. Call frequency peaked at 880 in FY 2000 with a steady decrease to 415 for FY 2004. Year-to-date in FY 2005, there have been 214 calls to the Helpline. PCAH staff has been assigned to analyze the data to identify reasons for the downward trend in usage, to research how other states promote their helplines, and to organize a committee to develop a marketing plan to promote the Nebraska Helpline. PCAH and MCH Planning & Support staff will continue to collaborate to take measures to increase use of the HMHB Helpline in FY 2006.

Title V funds have supported a variety of public health infrastructure developments for some time. Nebraska has been recognized nationally for its great strides in recent years to develop statewide local health departments with tobacco settlement funds. In the previous three years, a portion of Title V funds were set aside for subgranting with the local health departments eligible to receive Tobacco Settlement funds. An MCH capacity-building focus continues with the LB 692 recognized health departments. The funding mechanism with local health departments shifts to contracts from subgrants and the level of Title V funds for MCH community-level infrastructure increases in FY 2006. Contract negotiations with individual health departments will take into account the current infrastructure level and an assessment of the capacity-building activities needed to continue a steady expansion alongside the tobacco settlement investment. As for other community-based organizations, a requirement for receipt of Title V funds is that these organizations communicate their service plans

with their local health department and identify if sufficient capacity exists to support its plan. Title V also continues to support infrastructure at the state-level by internal allocations to 14 programs/administrative units.

Staff of MCH Planning & Support arranged for technical assistance to enhance Title V-funded activities now and in the future by hosting Program Development (logic model) workshops. Conducted by Ron Mirr, M.S.W., the workshops were held in November 2004 in Columbus and North Platte. In collaboration with the Office of Minority Health, the two-day training was repeated in Lincoln in May 2005 for Native American communities. Process evaluations were highly favorable from participants at each of the three sites. In addition, an outcome evaluation of the November 2004 workshops indicated that the majority of the respondents have used skills in the six months post-training.

A primary role of MCH Planning & Support is subrecipient monitoring, as required by the Office of Management and Budget (OMB), and described in the OMB Circulars. As part of NHHS single-agency audit, Title V/MCH has been diligent in its efforts to clear an earmarking audit finding over a 3-year period. For the third consecutive year, NHHS with the assistance of MCH Planning & Support has submitted public comment to OMB by suggesting changes to the OMB A-133 Compliance Supplement. The recommendations, if incorporated by OMB, would assist auditors in the correct interpretation of the Title V earmarking requirement. OMB had not released the 2005 Compliance Supplement at the time of this writing. The unresolved audit finding on earmarking puts Nebraska at risk of paying back any questioned costs, which NHHS maintains is unknown due to the incongruent forms, instructions, and audit guidance approved by OMB. Nebraska anticipates it will again submit recommended changes to the financial reporting forms in the MCH/Title V Guidance and Forms, OMB #0915-0172 which approval expires May 31, 2006.

In FY 2004, MCH Planning & Support worked with the University of Nebraska--Lincoln (UNL) Bureau of Sociological Research to negotiate "social capital" questions on their annual statewide phone survey. The Bureau has conducted the Nebraska Annual Social Indicator Survey (NASIS) for over 25 years, but had not previously selected questions of this nature. Believing in the importance of the measure, the Bureau agreed to add seven core questions on the Fall 2004 NASIS to establish a baseline. Data analysis of Nebraskans' social capital was not complete at the time of this writing. It is believed the results will help guide the methods to undertake action to increase civic participation, as a correlate to public health, and gauge methods to successfully obtain Nebraskans' input on the Title V plan.

MCH Planning & Support plans to take a lead role to expand and enhance communication with collaborative partners. For example, the Office of Family Health, drawing upon potential models identified in a report commissioned witht he University of Nebraska Public Policy Center, would be the catalyst for a Nebraska-based "virtual MCH institute" if sufficient implementation funds are identified. The institute would be responsible for creating and maintaining MCH capacity-building at individual, community and statewide levels. Additional partnerships being formed will address: 1) enhanced public input via statewide forums or town hall meetings, and 2) research on mothers' willingness to accept home visitation.

## F. TECHNICAL ASSISTANCE

With the five-year comprehensive needs assessment completed earlier this year, focused attention must now be given to strategy development. For many of the ten identified priority needs, programmatic and system level planning processes are underway, which the Offices of Family Health and Home and Community Based Services for Aged and Physically Disabled will engage in and utilize for determining mid and long term strategies. For instance, the Nebraska Cardiovascular Health Program published earlier this year a plan for nutrition and physical activity. This plan will guide the selection and implementation of strategies to address overweight among women, children and adolescents. Similarly, HHS Protection and Safety has begun development of a child abuse prevention plan, and will be collaborating with the Office of Family Health in its preparation.

As described in the needs assessment, specific attention was given to assessing MCH capacity to carry out the ten essential public health services, using the CAST-5 tool. Subsequently, the Office of Public Health led the assessment of the State Public Health System using the National Public Health Performance Standards. This latter process will be used to develop a new Nebraska Public Health Strategic Plan. With the wealth of information derived from these parallel, complementary processes, Nebraska is in an excellent position to create a strategic plan crafted specifically for MCH infrastructure capacity building. To do so, though, technical assistance is needed on bridging the two assessment processes and linking State Public Health System Planning with MCH capacity building planning.

Nebraska is therefore requesting technical assistance to design next steps in a MCH strategic planning process. Possible sources of the technical assistance would be the Women's and Children's Health Policy Center or the Oregon Office of Family Health. Specific assistance needed would be: means for doing a cross-walk between the two previously completed assessments; recommendations on any follow-up/targeted assessment; and a process for moving from the assessment findings to an integrated State Public Health/MCH strategic plan.

## V. BUDGET NARRATIVE

### A. EXPENDITURES

Nebraska has longstanding concerns with the budget and expenditure forms and instructions. Subsequently, the narrative in Sections V. A & V. B remains much the same as in the past two years. Our concerns stem from incongruent requirements of an annual report for a grant with a two-year period of availability of funds. Despite our best efforts to clarify and communicate concerns over time, to-date we believe these attempts have failed to be understood. We submitted written comments and recommended changes to Federal entities involved in the review, revisions, and re-approval of the Guidance and Forms in May 2003, although no significant revisions were made to the financial portion of the Guidance and Forms. As a result, this narrative attempts to re-clarify the limitations of the financial forms, as much to justify expenditures of Nebraska's Title V funds for FY 2004.

Our longstanding concerns were heightened for FY 2000 and FY 2001. Audits of those years resulted in Federal findings that Nebraska was not in compliance with the statutory earmarking requirements. The corrective action plan to resolve the finding was an extensive commitment of Title V administrative staff time, in consultation with a respected authority on federal policies affecting acquisition, administration and audit of Federal grants. We continue to strive for audit resolution for Nebraska, and we believe ultimately to improve the utility of the information while minimizing the reporting burden to all states.

The period of availability of the Federal MCH allotment allows expenditures in the fiscal year or the succeeding one, i.e. a two-year period (42 U.S.C. 703(b)). For example, the FY 2004 report should include expenditures of the allotment that can occur during the period October 1, 2003 - through September 30, 2005, although that is 21/2 months beyond the FY 2004 report due date of July 15.

The instructions for the annual report's financial forms are vague and contradictory. Form 3 instructions state: "columns labeled *expended* are to contain the actual amounts expended for the *applicable year*." (Emphasis added). *Applicable year* is not defined in the Glossary. Form 3 feeds into sequentially numbered forms, even further confusing the instructions for Form 4 and Form 5, stated: "enter the budgeted and expended amounts for the appropriate *fiscal year*." (Emphasis added). *Fiscal Year* is not defined either, although is generally understood to mean a 12-month period for accounting purposes, with a caveat that *Fiscal Year* is a 24-month period for an allotment with a two-year period of availability of funds. Without clear guidance, Nebraska opted to report expenditures "during" FY 2004 (October 1, 2003 - September 30, 2004), a combination of the FY 2003 and FY 2004 allotments. The attached table depicts the overlap of the two-year period of availability of funds with the fiscal year period, relative to the reporting due date. The shaded cells show the context of the expenditures submitted with this report.

Section 506(a)(1) of Title V, Social Security Act [42 U.S.C. 706] states generally the requirement for submitting an annual report. Section 506(a)(3)(E)(b)(1) states that expenditures from amounts received under Title V are to be audited not less than once every two years. The two-year audit period may have been intended to coincide with the period of availability of funds for the Federal allotment. Financial forms re-approved in May 2003 for the Block Grant Guidance & Forms, as part of the required annual report, are not designed for an audit of the two-year period in which an allotment can be expended. This audit limitation is especially critical for the earmarking requirement established in statute. To further confuse the requirement, the terms "payment" and "allotment" are used interchangeably in statute. [Section 705(a)]. Taken together, the provisions for earmarking and the period of availability of funds make a convincing case that the earmark must be met over the period for availability of funds, not over the single fiscal year in which funds are expended.

There is one especially bothersome aspect of the audit finding, and so the reason for our persistent approach to make clear the problems with the financial forms. The audit finding proposed questioned costs of $96,000 for the FY 2000 audit because the auditor was unable to determine if the State met

the expenditure requirement for at least 30% for preventive and primary care services for children. In our response to the proposed finding, we successfully argued that the questioned costs were unknown because the annual report did not require reporting expenditures of the allotment. A year later, without audit resolution, the auditors expanded the finding to include all the earmarks (30-30-10) through a scope limitation. (Note: Nebraska's audit findings are the result of the auditors' inability to test records, not due to our withholding information or preventing testing.) To-date we have not been required to pay back funds, however, until there is resolution, the finding remains.

Financial reporting in the FY 2004 Report, as in prior years, conforms to the required annual report format showing funds expended in a fiscal year. FY 2004 will be audited in August 2005. The table attached illustrates the incongruent requirements, causing the Federal audit finding for earmarking for three consecutive years, to date.

One possible solution is to maintain two separate record keeping systems, one for the required annual report based on fiscal year payments and another by expenditures of the allotment. Separate record keeping would be unnecessary if the annual reporting forms were revised to reflect the two-year expenditure of an allotment by subcategories of "Types of Individuals" and "Types of Services". Presently, accounting staff assigns codes to distinguish individual expenditures by allotment within a fiscal year. Additional coding could identify earmarked expenditures of an allotment across the two-year period of availability of funds. Pairing allotment with earmark coding would eliminate the need to keep two separate systems to be compliant with auditing and to continue submitting annual reports in the format prescribed by MCHB.

The local community subrecipients are monitored by line items budgets and expenditures to achieve the detail and accuracy to monitor Federal funds. Since subrecipient monitoring is also a compliance requirement, it is not an option to minimize reporting by scaling down those reports and only reporting the earmarked, subcategory expenditures. Although somewhat cumbersome to have subrecipients report both by line item and by category expenditures, this appears to be more feasible than to report one way to MCHB and to maintain another method to achieve audit compliance. We have urged that these data elements be reduced to the absolute minimum needed to allow for compliance with the statute authorizing the MCH Block Grant, i.e. the earmarked 30-30-10. Further, we have suggested that the fiscal data required by Section 706(a)(2)(iv) be combined with the requirement and timing for submission of the reporting required under 45 C.F.R. 96.30(b), i.e. OMB Standard Form 269A "Financial Status Report" (FSR). This would enhance the ability of all states to reconcile periodic financial reports submitted to the Federal government with their annual financial statements audited pursuant to OMB Circular A-133. Further, it would create the ability to demonstrate states' current carry-over authority available under Section 703(b) of the statute.

Without the additional accounting records of expenditures by allotment and earmarking, the auditors relied on the annual report (Form 4) to test if the earmarking requirement was met. Form 4 has two limitations to use it for auditing compliance: 1) expenditures are based on the fiscal year (not the expenditures of an allotment); and, 2) the expenditure column of Form 4 "Types of Individuals" combines the Federal expenditures with expenditures of State match ("Federal-State Partnership"), although earmarking is based on the Federal allocation only. 42 U.S.C. 706(a)(2)(iv). (See also, Legislative Briefing Title V Law Legal Compendium, New MCH State Leaders' Orientation Manual, October 2000, pg. 19). In other words, Form 4 does not identify earmarking expenditures because it is a combination of Federal and State funds, nor does it make the necessary distinction between expenditure of an allotment and expenditures in a fiscal year.

The FSR reflects the obligations and expenditures for the period of availability of funds, although the format does not incorporate the requirement to categorize expenditures by "Types of Individuals" (Form 4), nor "Types of Services" (Form 5), as required by U.S.C. 706(a)(2)(iv). The non-final FSR (due 15 months into and 9 months prior to the conclusion of the period of availability of funds) seeks obligation of unexpended funds for carry-over authority. The FSR is critical to the Form 2 budget and subsequently the remainder of the financial forms driven by it.

Budget-to-expenditure variations (Forms 3, 4, and 5) cannot be explained without discussing Form 2, albeit a budget form in a section to explain expenditures. Specifically, Line 2, Form 2 "Unobligated Balance" is problematic due to misinterpretation of several lines of the FSR, i.e. "Unobligated Balance" and "Unliquidated Obligations," which are similar phrases, but with a distinct difference for budgeting. The FSR seeks the "Unliquidated Obligations," i.e. obligated funds not yet expended. In a non-final FSR, Nebraska calculates "Unliquidated Obligations" as allotment minus outlay. In the final FSR, the same line must be zero. As stated on page 57 of the Block Grant Guidance & Forms, the MCHB instruction overrides the standard instruction for Standard Form 424, Line 15b. ("Applicant") by instructing applicants to report the "Unobligated Balance." That figure feeds Line 2, Form 2. If Form 2 sought the "Unliquidated Obligations" (obligated, unexpended funds) rather than the "Unobligated Balance", the budget would accurately reflect the new allotment plus the carryover from the previous allotment. Accordingly, the definition for "carryover" in the glossary should be revised. Since Nebraska reports zero "Unobligated Balance", our budget reflects only the new allotment. The difference is typically six figures. Nebraska exercises carry-over authority, although is unable to budget carry-over using the present form and instructions, so its grant expenditures exceed budget. A wide variance between budget and expenditures as with previous years, is explained primarily by the incompatible budget and expenditure reporting formats originating with the misinterpretation of the FSR, which feeds Form 2, Form 3, Form 4, and Form 5.

Form 4 requires that administrative costs be reported along with categories of "Types of Individuals". The staff responsible for the administration of Nebraska's MCH Block Grant do not provide services, although administrative costs must be reported among "Types of Individuals Served." Including administrative costs with expenditures for services detracts from the percentage for 30-30 earmarked expenditures, and could contribute to auditing irregularities. Administrative costs would be more logically and accurately reported on Form 5 as part of the subcategory "Infrastructure." Administrative functions contribute to state-level MCH infrastructure by needs assessment, planning, policy development, monitoring, building information systems, etc.

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## B. BUDGET

Much of what is requested for budget narrative has already been described in the Expenditure narrative, although in it budget features are addressed and clarified as they relate to expenditures. Our determination to make a shift in the context is due to the inextricable relationship of budget and expenditure, and our interpretation that statutory "maintenance of effort" and "earmarking" requirements are based on expenditures. The guidance and forms mistakenly connects these to budget. The Guidance for Section V. "Budget Narrative" confuses these distinctions by instructing the expenditure narrative to precede budget narrative. Logically, expenditures are "subsequent to" budget. Heading Section V. "Financial Narrative" would be more descriptive of the section content as it would be inclusive of budget and expenditures.

Budget and expenditures are necessarily intertwined. Understanding the particular function of budget and expenditure are important for accountability, as the use of funds is based in statutory requirements. It is not the intent to minimize the purpose of budgeting, although we believe it is responsible to emphasize our understanding that accountability is entirely related to expenditures. Expenditures, of course, are legitimized by a realistic budget.

An introductory statement in the budget Form 2 instruction states: "This form provides details of the State's MCH budget and *the fulfillment of certain spending requirements* under Title V for a given year." (Emphasis added.) Contrast budget as a plan for expenditures with actuality being the expenditure of funds. The fulfillment of spending requirements, i.e. "earmarking" and "maintenance of effort", comes with expenditure; it is not a direct result of budget alone. If compliance of earmarking

and maintenance of effort were based in budget, although they are not, Form 2 would be further misleading. Due to its limitation to budget carryover (see Expenditure narrative for detail), the earmarkings are percentages of the budgeted allotment, rather than the allotment plus carryover.

Amount, source, and time period are critical components in budget and expenditure. Form 2 seeks a budget overview of funds, including "Other Federal Funds" under the control of the person responsible for the administration of Title V. The format does not allow for subsequent report of actual expenditures of the budget amount of "Other Federal Funds." Further, some of these other Federal funds do not mirror the Title V fiscal year period of October 1-September 30, making it difficult to accurately understand the financial relationships between the various sources and amounts of funds to Title V.

Federal Title V support clearly complements Nebraska's effort. Nebraska's budgeted "maintenance of effort", based on FY 1989 State support, has consistently been surpassed. The source of non-Federal funds is a combination of State Comprehensive Systems and local funds and in-kind support to meet both maintenance of effort and the 3:4 match requirement. The largest single source of State support comes thru the Medically Handicapped Children's Program (MHCP). Other sources of State funds that complement Title V funding include support to the following programs: the Immunization Program for vaccine purchase, Newborn Metabolic Screening Program which also includes a cash fund from screening fees, Reproductive Health Program, and Birth Defects Prevention legislation to support genetic clinics at the University of Nebraska Medical Center.

The inadequacies of the financial forms to produce meaningful and accountable information is further demonstrated between Form 2, Form 3 and Form 4. Compliance with the 30-30-10% earmarkings is suggested on Form 2 budget, although we interpret the statutory earmarking requirements as the expenditure of allotment. The expenditure of the Federal allocation (Form 3) is shown separate from the earmarked categories of expenditures on Form 4, which are a combination of Federal and State funds. Form 4 cannot be used to determine earmarking compliance, as that is based on the Federal allotment alone. Form 5 is also plagued with similiar problems as Form 4, although not in the same statutory compliance since the Form 5 categories are not earmarked. (See Expenditure narrative regarding Form 5 relative to administrative cost and infrastructure.) If administrative costs were incorporated on Form 5, as suggested, Form 5 would need to identify the distinction between budget for Federal and State funds relative to the 10% earmark. We have previously asked on multiple occasions to have a clearer definition of "administrative costs," None of these requests for clarification have been satisfied.

Any significant year-to-year budget variations are difficult to discern, and subsequently to explain, in the present format and instruction limitations to these financial forms.
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## VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

## X. APPENDICES AND STATE SUPPORTING DOCUMENTS

### A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

### B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

### C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

### D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.